STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-00386

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 5, 2007 at 1:15 p.m., in Jacksonville, Florida. The petitioner was not present. However, he was represented by / , case worker and legal guardian. Appearing as witnesses for the petitioner were , foster mother and caseworker. The agency was represented by Cindy Barge, Agency for Healthcare Administration (AHCA). Appearing as witnesses for the agency were Teresa Ashey, Kepro and Dr. Robert Buzzeo, Kepro. Ms. Ashey and Dr. Buzzeo participated in the hearing by telephone. George Smith, Kepro, was a telephonic observer.

ISSUE

The petitioner disagrees with the agency's action of January 5, 2007 to approve 8 hours a day or 480 hours of private duty nursing instead of the requested 720 hours. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a 7 year old male with a diagnosis of other specified congenital anomalies of the brain, tracheostomy, epilepsy, and insomnia unspecified. On December 28, 2006, 720 hours or 12 hours daily of private duty nursing services was requested by the nursing service provider. The Kepro Unit evaluated the request to determine if medical necessity existed to approve the service at the requested level. The Kepro Unit's review states in part:

> "Initial PC Review:
> On 1/02/07 at 12:58pm, A Board Certified Pediatrician reviewed the case and made the following determination:
> 7 year old with unspecified congenital brain anomalies. Nursing assistance required for trach, O2, GT, meds. Patient lives in medical foster care. APPROVE RN: 720 hours 12/29/2006-02/26/2007, 12 hours at night Sun-Sat 7pm-7am. Upon return of the case to RNR it was noted that the PC had deviated from the current AHCA policy and provided no clarification regarding that deviation from AHCA policy. The RNR referred the case to a KePRO Medical Director who is a Board Certified Pediatrician for clarification. On 01/02/07 a 10:58 pm the Medical Director May the following determination: "7 year old with unspecified congenital brain anomalies. Nursing assistance required for trach, O2, GT, meds. Patient lives with medical foster care. Reviewed comments by first physician reviewer, which are not consistent with AHCA policy for patients cared for in a MFA home. Current policy states only 8 hours allowance for PDN in the MFC environment to be utilized at night only one of the MFC provider sleeps. I suggest that the AUTHORIZATION for PDN services be APPORVED for 8 hours only of PDN services, 7 days/week for the 60 cert period (12/29/2006-02/26/2006). This would be a total of 480 hours, therefore, 240 hours should be DENIED." The provider was notified of this decision on 01/03/07 at 10:34 am and provided with information regarding the option of requesting a Reconsideration review.

> RECONSIDERATION: On 1/03/07 at 7:30 am, a Reconsideration review was completed by a second Physician Consultant who is Board-Certified in Pediatrics and resulted in the following determination. "I have read the reconsideration request from provider dated 1/03/07. There is no further information that was submitted to support additional PDN services other than the 8 hours/day, 7 days/week for a total of 480 hours for the stated cert period of 12/29/06 to 02/26/07. DENIAL of four (4) hours/day, 7 days/week or a total of 240 hours is UPHELD."

The Kepro Unit determined that based on information provided the petitioner was eligible for 480 hours of private duty nursing or 8 hours a day instead of the requested 720 hours. The agency substantiated its decision by referring to policy that restricts the number of private duty nursing service hours to a maximum of 8 hours per day for a foster care residence. The petitioner was notified of the agency's decision on January 3, 2007. A reconsideration was performed and the original decision was upheld with notification being provided on January 4, 2007. The petitioner requested a Re-Reconsideration and the denial decision was again upheld.

The petitioner's condition is medically complex. He requires frequent suctioning and trachea care and replacement to clear obstructions for oxygenation. He is nonverbal, incontinent, and visually impaired. The petitioner requires total care for all aspects of bathing, dressing, toileting, grooming, and hygiene. The petitioner must be repositioned frequently to maintain skin integrity and pulmonary hygiene. The petitioner receives all medications through a gastric tube and must be monitored closely for reflux and aspiration. The petitioner must also be monitored for seizures. The petitioner lives in a medically needy foster home with his foster mother, her husband and four other children.

The foster mother requested the additional nursing care so that she can attend to the other children, so she can get additional sleep and so she can attend to her own hygiene needs. The petitioner's foster mother reported that she typically goes to bed at 11:30 pm and she awakes at 6:00 am which only gives her 61/2 hours of sleep a night. The agency representative explained that there is no exception to the 8 hour maximum on private duty nursing services in a foster care situation and she explained that the service cannot be approved for the convenience of the provider or recipient.

The agency representative referred to an AHCA memo dated June 8, 2006 as justification for the 8 hour limit of private duty nursing services. This memo indicated private duty nursing services can only be provided to a medical foster home at night to provide continuous or frequent intervention.

CONCLUSIONS OF LAW

Pursuant to the Florida Administrative Code at 59G-1.010 **Definitions**, which states in part:

> "(166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) 'Medically necessary' or 'medical necessity' for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

Fla. Stat. § 409-905, states in part:

"(4) (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. When implemented, the private duty nursing utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative."

The Home Health Services Coverage and Limitations Handbook dated October 2003 states in part:

"**Private Duty Nursing Definition**
Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition. Who **Can Receive Private Duty Nursing** Medicaid reimburse private duty nursing services for recipients under the age of 21 who:
Have a complex medical problems; and
Require more individual care than can be provided through a home health nurse visit...**Parental Responsibility** Private duty nursing services are authorized to supplement care provided by parents and caregivers.

> Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver. "

The record shows that the petitioner requested to be approved to receive 720 or 12 hours daily of private duty nursing service. The agency referred the case to the Kepro Unit for a prior authorization evaluation. The Kepro unit evaluated the information provided and determined that the petitioner should be approved for 480 or 8 hours daily of private duty nursing services because AHCA policy restricts private duty nursing services to 8 hours a night in a medical foster care home while the medical foster care provider sleeps. The agency's determination was also based on the medical necessity criteria and the description of private duty nursing service found in the Coverage and Limitations handbook. The agency representative referred to provider qualification and enrollment information which requires that a Medicaid Medical Foster Care Provider be available 24 hours a day to provide services and that a Medicaid Medical Foster Care Provider notify staff when unable to provide services for a child in their care.

The petitioner's mother disagreed with the agency's decision and argued that 8 hours of private duty nursing is insufficient because it does not leave her enough time to take of her personal needs, get 8 hours sleep, and properly take care of other children.

In carefully comparing the evidence presented to the applicable authorities, the hearing officer concludes that the agency's action to approve 8 hours daily of private duty nursing service instead of the requested 12 hours daily is a justified action that is in accordance with the above cited authorities.

DECISION

This appeal is denied.

NOTICE OF RIGHT TOAPPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 16th day of April, 2007,

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-00973

PETITIONER,

Vs.

CASE NO. 1210800136

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 88125

RESPONDENT.
_____/

ORDER OF STIPULATION

This matter having come before me on the stipulation entered herein, by and between the parties, a copy of which is attached hereto and incorporated herein by reference. It is hereby ordered that the stipulation is approved and adopted, as the order of the undersigned-hearing officer.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 88125

RESPONDENT.

APPEAL NO. 06F-00973

CASE NO. 1210800136

STIPULATION

Petitioner, ("Petitioner") and Respondent, FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES ("DEPARTMENT"), by and through their respective undersigned Counsel, hereby enter into the following Stipulation in settlement of the above captioned proceeding:

1. Petitioner hereby stipulates that on November 5, 2004, he was placed in a nursing home under the Institutional Care Program (ICP).

2. On Petitioner's initial application for benefits dated December 3, 2004, his designated representative s declared SSA income, no assets and no closed bank account in the last 3 years.

3. Petitioner's benefits for the MIM / ICP program were approved from November 2004 to December 2005.

4. During Petitioner's January 2006 redetermination for benefits, it was discovered that in September 2004, Petitioner possessed $44,452.58 in his Suntrust Bank Account No. 4 and $10,351.25 in his Suntrust Bank Account No.

5. Petitioner stipulates that for Medicaid purposes his assets in September 2004, were $54,803.83 and that those assets were transferred by his designated representative , to his son, in September 2004.

6. Petitioner stipulates that the transfer of the assets took place during the applicable Medicaid look back period of thirty-six (36) months and that he is therefore ineligible to receive Medicaid benefits for sixteen (16) months, ie. until January 2006.

7. Petitioner further stipulates that the sixteen (16) month period was reached as follows: As the transfer was made prior to June 1, 2006, the private pay nursing home rate of $3,300 is used as a divisor of the total asset amount of $54,803.83, resulting in a sixteen (16) month ineligibility period beginning the month the transfers occurred, which would be September 2004 through December 2005.

8. The Department therefore stipulates that Petitioner is entitled to receive MIM / ICP benefits commencing January 2006 and shall process Petitioner's benefits accordingly.

9. The Hearing Officer in the above referenced action is hereby authorized by the parties to file a Notice of Dismissal With Prejudice.

10. The parties have agreed to bear their own respective attorney fees and costs in this action.

11. The undersigned hereby represent that they have the authority to enter into this Stipulation according to the terms as stated in the foregoing.

DATED this 5th day of April, 2007.

By: _____
MARK LAWRENCE, ESQ.
Attorney for Petitioner
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By: _____
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Miami, FL 33128
Telephone: (305)377-5080
Facsimile: (305) 377-5975

DONE and ORDERED this 16th day of April, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-07647

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 23 Hillsborough
UNIT:

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 21, 2007, at 2:42 p.m., in Tampa, Florida. The petitioner was present to testify and represented herself. Ron Basalke, senior human services program specialist with the Agency For Health Care Administration (AHCA), represented the respondent and also testified. Kevin Murdy, manager with MMG Transportation, appeared as a witness for the respondent.

ISSUE

At issue is the respondent's decision of November 21, 2006 to deny the petitioner transportation services based on the allegation by the transportation provider, MMG Transportation, that the petitioner exhibited uncooperative behavior. The petitioner is seeking continued bus transportation services.

FINDINGS OF FACT

The respondent, through the transportation provider MMG transportation, sent notice to the petitioner in November 2006 that her bus transportation privileges were terminated based on the assertion that the petitioner had exhibited uncooperative behavior. The petitioner received this notice on November 21, 2006. The petitioner disputes the merit of this allegation. However, the merit of this allegation was not sufficiently developed to render a factual finding on such.

The transportation provider, MMG Transportation, stipulated at the hearing to continue providing transportation services to the petitioner, and agreed to rescind the prior denial action. The petitioner surfaced a second issue during the hearing regarding a later alleged refusal of MMG Transportation to provide transportation to a specific oncologist. Since this instant appeal was requested on November 29, 2006 and this second surfaced issue did not arise until January 2007, it is not part of this instant appeal. The petitioner elected to first seek resolution of this second requested issue with MMG Transportation prior to requesting an appeal on this specific matter.

CONCLUSIONS OF LAW

The Findings of Fact show that the respondent agency stipulated to rescind its prior intended termination of transportation services, and agreed to continue to provide transportation services to the petitioner. This hearing authority's jurisdiction is limited to specific benefit matters, as set forth in Florida Administrative Code Rule 65-2.056, as below:

65-2.056. Basis of Hearings.
The Hearing shall include consideration of:
(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
(2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.
(3) The Hearing Officer shall determine whether the action by the agency was correct at the time the action was taken.

This hearing authority's jurisdiction does not include the respondent agency's administration of the program per se, except as such pertains to the provision of a specific benefit determination. Findings show that the Department has agreed to continue to provide the transportation services benefit that had been previously denied. Since the respondent has stipulated to continue the transportation benefits previously terminated, and this hearing authority's jurisdiction is limited to benefit issues as above, this appeal is denied or dismissed as moot.

DECISION

This appeal is denied as moot in view of the fact that the respondent has stipulated to continue the transportation services provided by MMG Transportation.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin

the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 2 day of April, 2007,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-06761

PETITIONER,

Vs.

CASE NO. 1224137426

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 88601

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 31, 2007, at 2:30 p.m., in Opa Locka, Florida. The petitioner was not present but was represented by . Esquire. The Department was represented by Vincent Dunn, district legal counsel. Cathy Mugarra, economic self-sufficiency specialist II, appeared as a witness for the Department. This hearing was previously scheduled for November 22, 2006 and December 22, 2006, but was continued at the respondent's request. The record was initially left open for 15 days for the respondent to submit additional information. On February 13, 2007, a letter was received from Sandra Piligian, deputy district legal counsel, requesting a 21 day extension of time to prepare a letter brief. The petitioner was in agreement and also requested the same extension of time to file his letter brief. Even though the petitioner's closing brief was filed untimely, it will be considered by the hearing officer, as it sets forth his argument in the case. On February 13, 2007, the undersigned hearing officer received from the

petitioner a "Motion to Continue the Benefits" based on the contention that the hearing was requested within the ten days specified for the continuance of the benefits. Ruling on this motion will be explained in the Conclusions of Law.

ISSUE

The petitioner is appealing the Department's action of September 26, 2006, to terminate her Institutional Care Program (ICP) benefits effective October 31, 2006, due to excess income.

FINDINGS OF FACT

On October 9, 2006, the petitioner requested a hearing related to the Department's action of September 26, 2006, to terminate ICP benefits. Prior to the issue under appeal, was in receipt of these benefits. On September 26, 2006, during a review of her case, the Department was made aware that the petitioner had a monthly income, which was not initially reported, in the amount of $1,446.66 from General Electric Capital Assurance Company long term care policy. At that time, had income from the Social Security Administration, in the amount of $814 monthly.

The Department's eligibility specialist determined that gross available monthly income of $2,260.66 exceeded the Department's income limit of $1,809 for 2006. As a result, on September 26, 2006, the Department determined that was no longer eligible for ICP and Medicaid benefits. A Notice of Case Action was mailed to on the next date, informing her that her ICP and

Medicaid benefits would stop as of October 31, 2006, on the basis that her income exceeded the Department's eligibility standards.

The petitioner is not disputing the income amount; however, the petitioner's position is that the money that is being paid under the long term care policy should be excluded in the ICP eligibility and payment process because this income is not listed in any regulation.

CONCLUSIONS OF LAW

Applicable authorities in this matter appear in 20 C.F.R. 416 as follows:

§ 416.1102 What is income?
Income is anything you receive in cash or in kind that you can use to meet your needs for food and shelter. Sometimes income also includes more or less than you actually receive (see § 416.1110 and § 416.1123(b)). In-kind income is not cash, but is actually food or shelter, or something you can use to get one of these.

§ 416.1103 What is not income?
Some things you receive are not income because you cannot use them as food or shelter, or use them to obtain food or shelter. In addition, what you receive from the sale or exchange of your own property is not income; it remains a resource. The following are some items that are not income:..
(5) Cash provided by any nongovernmental medical care or medical services program or under a health insurance policy (except cash to cover food or shelter) if the cash is either:
(i) Repayment for program-approved services you have already paid for; or
(ii) A payment restricted to the future purchase of a program-approved service.
Example: If you have paid for prescription drugs and get the money back from your health insurance, the money is not income.

§ 416.1104 Income we count.
We have described generally what income is and is not for SSI purposes (§ 416.1103). There are different types of income, earned and unearned, and we have rules for counting each. The earned income rules are described in § § 416.1110 through 416.1112 and the unearned income rules are described in § § 416.1120 through 416.1124. One type of unearned income is in-kind support and maintenance (food or shelter). The way we value it

depends on your living arrangement. These rules are described in § § 416.1130 through 416.1148 of this part. In some situations we must consider the income of certain people with whom you live as available to you and part of your income. These rules are described in § § 416.1160 through 416.1169. We use all of these rules to determine the amount of your countable income--the amount that is left after we subtract what is not income or is not counted.

§ 416.1120 What is unearned income.
Unearned income is all income that is not earned income. We describe some of the types of unearned income in § 416.1121. We consider all of these items as unearned income, whether you receive them in cash or in kind.

§ 416.1121 Types of unearned income.

Some types of unearned income are--
(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

§ 416.1124 Unearned income we do not count.

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the $20 general exclusion described in paragraph (c)(12) of this section.
(b) Other Federal laws. Some Federal laws other than the Social Security Act provide that we cannot count some of your unearned income for SSI purposes. We list the laws and the exclusions in the appendix to this subpart which we update periodically.
(c) Other unearned income we do not count. We do not count as unearned income--
(1) Any public agency's refund of taxes on real property or food;
(2) Assistance based on need which is wholly funded by a State or one of its political subdivisions. (For purposes of this rule, an Indian tribe is considered a political subdivision of a State.) Assistance is based on need

when it is provided under a program which uses the amount of your income as one factor to determine your eligibility. Assistance based on need includes State supplementation of Federal SSI benefits as defined in subpart T of this part but does not include payments under a Federal/State grant program such as Temporary Assistance for Needy Families under title IV-A of the Social Security Act;
(3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses. However, we do count any portion set aside or actually used for food or shelter;
(4) Food which you or your spouse raise if it is consumed by you or your household;
(5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster. See § 416.1150 for a more detailed discussion of this assistance, particularly the treatment of in-kind support and maintenance received as the result of a major disaster;
(6) The first $60 of unearned income received in a calendar quarter if you receive it infrequently or irregularly. We consider income to be received infrequently if you receive it only once during a calendar quarter from a single source and you did not receive it in the month immediately preceding that month or in the month immediately subsequent to that month. We consider income to be received irregularly if you cannot reasonably expect to receive it.
(7) Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985: met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983; and was eligible for SSI;
(8) Payments for providing foster care to an ineligible child who was placed in your home by a public or private nonprofit child placement or child care agency;
(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of the separate burial fund. (See § 416.1231 for an explanation of the exclusion of burial assets.) This exclusion from income applies to interest earned on burial funds or appreciation in the value of excluded burial arrangements which occur beginning November 1, 1982, or the date you first become eligible for SSI benefits, if later;
(10) Certain support and maintenance assistance as described in § 416.1157;
(11) One-third of support payments made to or for you by an absent parent if you are a child;
(12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of

another (see § 416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The $20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in § 416.1124(c)(2). If you have less than $20 of unearned income in a month and you have earned income in that month, we will use the rest of the $20 exclusion to reduce the amount of your countable earned income;
(13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI as a blind or disabled person for the month before you reached age 65. See § § 416.1180 through 416.1182 for an explanation of plans to achieve self-support and for the rules on when this exclusion applies;
(14) The value of any assistance paid with respect to a dwelling unit under--
(i) The United States Housing Act of 1937;
(ii) The National Housing Act;
(iii) Section 101 of the Housing and Urban Development Act of 1965;
(iv) Title V of the Housing Act of 1949; or
(v) Section 202(h) of the Housing Act of 1959.
(15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;
(16) The value of any commercial transportation ticket, for travel by you or your spouse among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by you or your spouse and is not converted to cash. If such a ticket is converted to cash, the cash you receive is income in the month you receive the cash;
(17) Payments received by you from a fund established by a State to aid victims of crime;
(18) Relocation assistance provided you by a State or local government that is comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by section 216 of that Act;
(19) Hostile fire pay received from one of the uniformed services pursuant to 37 U.S.C. 310;
(20) Interest or other earnings on a dedicated account which is excluded from resources. (See § 416.1247);
(21) Gifts from an organization as described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code, to, or for the benefit of, an individual who has not

> attained 18 years of age and who has a life-threatening condition. We will exclude any in-kind gift that is not converted to cash and cash gifts to the extent that the total gifts excluded pursuant to this paragraph do not exceed $2000 in any calendar year. In-kind gifts converted to cash are considered under income counting rules in the month of conversion; and
> (22) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act."

Fla. Admin. Code 65-2.048 Action to Reduce or Discontinue Assistance or Service in part states:

> (1) In all programs other than the Food Stamp Program a hearing request filed within ten (10) days after the date of mailing or hand delivery of the notice either orally or written, requires that assistance be continued at the current level until the final written decision of the Hearings Officer is rendered...

The Findings of Fact shows that the petitioner did not file a hearing request within the ten days allowed for the benefits to be continued at the prior level. Therefore, based on the above cited authority, the hearing officer denies the petitioner's "Motion to Continue the Benefits".

The petitioner has argued that the payments made to the petitioner from the General Electric Capital Assurance Company Long Term Care Policy should be excluded in the ICP eligibility and payment process. The petitioner relies on the language in 20 C.F.R. s. 416.1221(a) arguing that the income is not "related to prior work or service", and therefore, fails the test of income that should be include. However, the listing of income in s. 416.1221 is not an all inclusive list of income. The section begins "Some types of unearned income are--"

This order includes a more comprehensive listing from the regulations. Section 416.1102 What is income, starts by stating that "Income is anything you receive in cash or in kind that you can use to meet your needs for food and shelter." The petitioner can use this payment to meet her needs. Section 416.1103 What is not income, excludes certain items from being considered as income. There is only one of the list exclusions that requires review. It is:

> (5) Cash provided by any nongovernmental medical care or medical services program or under a health insurance policy (except cash to cover food or shelter) if the cash is either:
> (i) Repayment for program-approved services you have already paid for; or
> (ii) A payment restricted to the future purchase of a program-approved service.
> Example: If you have paid for prescription drugs and get the money back from your health insurance, the money is not income.

There was no evidence to show that the payment from the long term care policy was a reimbursement for expense. In fact, the petitioner is seeking to have Medicaid pay the expense.

None of the other regulations provide an exclusion for the income from the long term care policy. Additionally, the Department has sent out statewide instructions clarifying how these policies are to be considered under the federal regulations and state rule which is consistent with those authorities. The hearing officer concluded that the Department correctly included these payments in determining the petitioner's eligibility for Medicaid ICP benefits and properly terminated her benefits.

DECISION

The appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 3rd day of April, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished T

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

Vs.

APPEAL NO. 06F-07483

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 03 Lafayette
UNIT: 88674

CASE NO. 1238243363

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on January 30, 2007, at 11:30 a.m., in Live Oak, Florida. The petitioner was not present. Present representing the petitioner was administrator, r. The Department was represented by Joanne Townsend, ACCESS processor. Present as a witness for the Department was Janet Southwell, Comprehensive Assessment and Review for Long Term Care Services (CARES) unit, Department of Elder affairs. At the request of the petitioner, the hearing was reconvened on March 9, 2007, at 1:40 p.m. in Live Oak, Florida. The petitioner was not present. Present representing the petitioner was . The Department was represented by Norman Crawford, ACCESS supervisor. Present as witnesses for the Department were Joanne Townsend,

ACCESS processor, Sam Rutledge, supervisor CARES unit, Department of Elder Affairs and Janet Southwell, CARES unit, Department of Elder Affairs.

The record was held open for 21 days to give the Department the opportunity to submit the governing authority related to the CARES unit withholding of the petitioner's level of care. The record was also held open for an additional 10 days to allow the petitioner the opportunity to respond to the authority submitted by the Department. The hearing officer did not receive any additional evidence or copies of the authorities from the Department subsequent to the hearing.

ISSUE

The petitioner is appealing the Department's action of September 14, 2006, to deny his application for Institutional Care Program Medicaid benefits. The petitioner is requesting Institutional Care Program Medicaid benefits from January 2006 through July 2006.

FINDINGS OF FACT

The petitioner was a resident of Lafayette County, Florida. On January 13, 2006, he was admitted into [redacted] which is a skilled nursing facility. The petitioner was admitted into the facility from Doctor's Memorial Hospital in Perry, Florida. The petitioner was diagnosed with uncontrolled diabetes mellitus, bronchitis, prostatic hypertrophy, left inguinal hernia, scrotal abscess, lesions to his posterior ileum and hypertension. The petitioner was incoherent upon admission and was unable to do any activities of daily living, turn himself or transfer himself. The petitioner has a history of being a juvenile sexual offender, which the facility was not aware of until after his admission. When the facility discovered that the petitioner had a history of being a

juvenile sexual offender they posted a sign on the door to his room that stated that minors were not to enter the room without seeing the nurse. The petitioner's condition slowly improved and he was discharged on July 1, 2006. There were no incidents reported of inappropriate behavior on the part of the petitioner while residing at the facility.

On June 22, 2006, the petitioner filed an application for Institutional Care Program Medicaid benefits. On June 29, 2006, CARES staff went to the facility to determine whether the petitioner met the level of care criteria. At the time of the visit, CARES became aware of the fact that the petitioner would be discharged soon as his health had improved. CARES withheld the petitioner's level of care as he was a juvenile sexual offender and could pose a danger to others. However, during the hearing, the Department of Elder Affairs, CARES, acknowledged that the petitioner met the level of care criteria from the date of admission through the date of discharge.

On September 14, 2006, the Department denied the petitioner's application for Institutional Care Program benefits because CARES withheld his level of care.

CONCLUSIONS OF LAW

42 C.F.R. § 483.132 Evaluating the need for NF services and NF level of care. In part states:

> (c) Data. At a minimum, the data relied on to make a determination must include:...(2) Evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others);...

Fla. Admin. Code 59G-4.180 and 59G-4.290 establishes criteria, which must be met in order for nursing, and rehabilitation services to qualify as intermediate care

services or skilled services. For an individual to be eligible for Institutional Care Program benefits he must meet the level of care criteria set forth in the above rules.

Fla. Admin. Code 59G-4.180 in part states:

Intermediate Care Services. (1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid.
(2) Definitions as used in this section.
(a) Intermediate care nursing home resident. A Medicaid nursing home applicant or recipient who requires intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment provided in a hospital or that which meets the criteria for skilled nursing services.

Fla. Admin. Code 59G-4.290 in part states:

Skilled Services. (1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitative services to qualify as skilled services under Medicaid.
(2) Definitions as used in this section.
(a) Continuous. The need for 24-hour care in a skilled nursing facility with professional nursing services available.

Fla. Integrated Pub. Policy Manual, passage1440.1300 in part states:

APPROPRIATE PLACEMENT (MSSI) To qualify for the Institutional Care Program (ICP) or Home and Community Based Services (HCBS), or the Program for All-Inclusive Care for the Elderly (PACE), the individual must meet special institutional eligibility criteria, including "appropriate placement."

Appropriate placement means that an individual must be placed in a facility or program certified to provide the type and level of care the department has determined the individual requires.

Two basic requirements must be met for placement to be considered appropriate. These are:

> the person must be determined by the department to be medically in need of the type of care provided by the specific program, AND
>
> the person must be actually receiving the services (or for HCBS, must be enrolled in the waiver) which the department has determined that the individual needs.
>
> To be appropriately placed for ICP, a person must have been determined in need of an ICP level of care (by CARES) and actually be placed in a Medicaid facility which provides the specified level of care.

To qualify for the Institutional Care Program Medicaid, the individual must meet special institutional eligibility criteria, including appropriate placement. Appropriate placement means that an individual must be placed in a facility or program certified to provide the type and level of care the Department has determined the individual requires. To be appropriately placed, CARES must determine that the individual is in need of an Institutional Care Program level of care.

The Findings of Fact show that the petitioner met the level of care criteria from the date of admission through the date of discharge. There was no medical evidence or authority presented that established that the petitioner did not need skilled nursing care or to support withholding the level of care. Based on these findings, it is determined that the level of care was inappropriately withheld. Therefore, the Department erroneously denied the petitioner's application for Institutional Care Program benefits for June 2006 and July 2006 and for the retroactive months of March 2006, April 2006 and May 2006.

> Fla. Admin. Code 65A-702(2) in part states:
>
> Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the

> three months immediately preceding the month of application (called the retroactive period). Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month, with the following exceptions...

The Findings of Fact show that on June 22, 2006, the petitioner submitted an application for Institutional Care Program Medicaid benefits. Based on the above rule, the date eligibility for Medicaid begins can include the three months immediately preceding the month of application. Medicaid eligibility does not include any month prior the three retroactive months which in this case are March 2006, April 2006 and May 2006. Based on the above rule, it is concluded that the Department was correct to deny the petitioner's request for Institutional Care Program Medicaid benefits for the months of January 2006 and February 2006 as those months were prior to the earliest month that Medicaid eligibility could begin.

DECISION

The appeal is denied as related to the months of January 2006 and February 2006.

The appeal is granted as related to the months of March 2006 through July 2006. Institutional Care Program Medicaid benefits are to be authorized for the above months provided the petitioner meets all other factors of eligibility in the Medicaid Institutional Care Program.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with

the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of April, 2007,

in Tallahassee, Florida.

Morris Zamboca

Morris Zamboca
Hearing Officer
Building 5, Room 203
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Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06N-00275

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 21, 2007, at 2:35 p.m., at in Miami, Florida. The petitioner was not present, but was represented by , attorney. Present on behalf of the petitioner were the petitioner's sons and , the petitioner's daughter, and the petitioner's ex-wife, The respondent nursing facility was represented by , attorney. Appearing as witnesses for the nursing home were administrator and business manager.

ISSUE

At issue is the discharge notice of December 5, 2006, for failure of to pay his outstanding bill. The nursing home has the burden of proof that the discharge is in compliance with the Code of Federal Regulations at 42 C.F.R. § 483.12.

FINDINGS OF FACT

The petitioner, , is presently a resident of . He is incapacitated due to a stroke. The petitioner had been approved for Institutional Care Program and Medicaid benefits (ICP) until such benefits were terminated by the Department of Children and Families (DCF) effective December 31, 2005, due to excess assets. Proposed Stipulation presented by the counsel for the petitioner (Petitioner Composite Exhibit 1) indicates that on September 9, 2004, the petitioner possessed $44,452.58 in petitioner's Sun Trust Bank Savings Account No. , and that after deducting petitioner's $3,600 Medicaid allowance, petitioner's assets on September 9, 2004 were $40,852.58 and that those assets were transferred by petitioner in September 2004.

The facility has not been paid since December 2005. The petitioner has an outstanding facility bill of about $76,543, as of the date of this hearing. On December 5, 2006, the facility generated notice that the petitioner was being discharged from the facility effective January 5, 2007, because:

> "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay."

The nursing facility intends to proceed with the discharge action based on non-payment. The listed discharge location on the notice dated December 5, 2006 is the home of , petitioner's son.

The counsel for the petitioner purported that the petitioner received the first notice from the respondent on November 21, 2006, and explained that they had only three months to deal with the Department of Children and Families (DCF) and resolve the issue.

The counsel for the facility responded that the petitioner was aware that the facility has not been paid for over a year and noted that the petitioner has postponed three times the hearing related to the DCF determination. Additionally, the counsel for the facility noted that the family has rejected generous settlement proposals to resolve the issue.

At the hearing, both parties stipulated that the family immediately will pay a $5,000 deposit and the facility will agree to withhold discharge of the petitioner pending the outcome of the hearing related to the termination of Medicaid benefits. The hearing officer agreed to postpone his ruling on the discharge issue until a determination is made on the Medicaid issue. The counsel for the petitioner noted that reserves the right to seek a judicial review in the District Court of Appeal if the hearing officer denies any of the appeals.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment. Federal Regulations do permit a discharge for this reason, as set forth at 42C.F.R. § 483.12(a)(2)(v), as follows:

> The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...

The Findings of Fact establish that the petitioner had an unpaid past due balance of $76,543 owed the facility as of February 21, 2007. The facility has given s a reasonable and appropriate notice of the need to pay for his stay at the facility and no financial arrangements have resulted. Therefore, it is concluded that the petitioner received "reasonable and appropriate" notice to pay for his stay at the facility, as required in the language of the above federal regulation.

The respondent nursing facility has valid reason to discharge the petitioner based on non-payment. However, the nursing facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action. Therefore, the nursing facility is concluded to have met its burden of proof in this specific discharge action based on non-payment.

DECISION

The appeal is denied as the action to discharge is correct and in accordance with Federal regulations.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 19th day of April, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
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Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01045

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 10 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 16, 2007, at 9:54 a.m., at the Sony Service, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's foster mother, The Agency was represented by Helena Glassberg, program administrator, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the agency was Teresa Ashey, review operation supervisor from KePRO. was present as an observer (via the telephone). KePRO is located in Tampa, Florida.

ISSUE

At issue is the Agency's action of February 7, 2007, to deny the petitioner's request for home health aide services from 480 hours of the service to 0 hours of the service for

the period of December 10, 2006 through February 7, 2007. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about ten years of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. The petitioner has also been recently approved under the Developmental Disabilities Medicaid Waiver Program. AHCA as noted above, will be further addressed as the "Agency".

KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on February 7, 2007, that the petitioner's request for 480 hours of home health aide service was going to be denied/reduced to 0 hours for the period of December 10, 2006 through February 7, 2007. The Agency's witness indicated that after review of the information provided to KePRO, from the petitioner's provider, did not indicate a need for the home health aide services for the petitioner. The petitioner requested a timely hearing and the previously approved benefits of four hours a day of home health aide were reinstated.

A reconsideration of the above decision was requested. The reconsideration review upheld the original denial of the requested services.

The petitioner submitted as evidence, Petitioner Exhibit 1, which contains a copy of a statement from the petitioner's treating physician. This letter by Dr. ....., dated March 7, 2007, states in part: "...He requires constant supervision with bathing, dressing,

eating and administering medication. He is also in need of PT., OT, ST. I therefore request an increase in his home health hours from four to six hours daily..."

After listening to testimony from the petitioner's representative at the hearing; KePRO stipulated that it was willing to provide four hours a day of the home health aide benefits to the petitioner. The petitioner's representative agreed with this decision and asserted that she herself did not request six hours a day of the service but agreed with the four hours of the service being currently provided to the petitioner.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...

The Agency, through KePRO, took action on February 7, 2007 to deny the petitioner's request for home health aide services for 480 hours of the service to 0 hours of the service for the period of December 10, 2006 through February 7, 2007. This decision was based on the information as provided by the petitioner's service provider and the petitioner's medical necessity need of the request for the service.

The petitioner's representative argued that the information as quoted by the respondent that was provided to the respondent from the petitioner's provider was not accurate. After listening to the petitioner's representative at the hearing; the respondent (KePRO) stipulated that fours hours a day of the home health aide service could be provided. The petitioner's representative agreed with this stipulation.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer orders the Agency, as per Agency stipulation, to provide the petitioner with four hours a day of the home health aide service.

DECISION

This appeal is granted as stated in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 16th day of April, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01026

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 10 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 27, 2007, at 9:25 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by her mother

The Agency was represented by Halina Glassberg, program operations administrator. Present on the telephone from Kepro was Dr. Galdino Silvaineto, physician. Also present was Susan Ziebell and Theresa Ashey, review operations supervisors.

ISSUE

At issue is the Agency's January 23, 2007 action of reducing the petitioner's skilled home nursing services from 24 hours daily 7 days per week, to 12 daily hours 7 days per week. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a one-year old child, date of birth March 25, 2006. She has been receiving skilled home nursing services of 24 hours daily, 7 days per week. She has a twin brother receiving Medicaid benefits, however this appeal is only for the petitioner. There are four notices to the petitioner informing her about her skilled home nursing services. Included in the evidence is a copy of a Recipient Denial Letter, dated January 21, 2007, stating that 1440 hours of skilled home nursing services were denied, and zero hours were approved for her from January 27, 2007 to March 27, 2007.

Since the January 21, 2007 Recipient Denial Letter did not have the petitioner's address, another Recipient Denial Letter, dated January 22, 2007, with the petitioner's old address was sent, stating the same that the January 21, 2007 Recipient Denial Letter said. A Recipient Reconsideration Denial Overturned Letter was sent, dated January 23, 2007, stating that the petitioner's skilled home nursing services was approved for 720 hours, which is 12 hours daily, 7 days per week, effective January 27, 2007.

A Recipient Reconsideration Denial Upheld Letter, dated January 27, 2007, was sent upholding the determination that the petitioner would receive 720 hours of skilled home nursing services, which is 12 hours daily, 7 days per week. The petitioner is currently at her new present address at:

The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the skilled home nursing services of 720 hours was determined to be medically necessary.

Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated January 17, 2007, stating that the petitioner was diagnosed

with a short gestation, which was 25-26 week gestation, apnea, unspecified hypothyroidism, unspecified paralysis of vocal cords, and esophageal reflux. Included in the evidence is a copy of a Kepro Synopsis of Case report, concerning the reconsideration, dated January 22, 2007, recommending that the petitioner be provided with 12 hours of daily skilled home nursing services, and 408 hours of services from a home health aide. This was after a second board certified consultant, who is board certified in pediatrics reviewed the petitioner's medical records. It was noted that the home health aide services would not be approved until it is requested by the provider.

The reconsideration took into account the petitioner's mother's concern about coverage of care by providing a combination of skilled nursing services, home health aide services, care by her mother who does not work, and her father when he is home from work. This was considered re-reconsideration because it was a second reconsideration. According to Dr. Galdino Silvaineto at the hearing, he agrees with the reduction of the skilled home nursing services for the petitioner. Included in the evidence from the petitioner is a copy of a statement from Dr. . dated February 22, 2007, stating that it is essential that the petitioner receive skilled home nursing service.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Fla. Admin. Code 59G4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that skilled home nursing services must be ordered by the attending physician, and

documented as medically necessary. The petitioner was receiving skilled home nursing services of 24 hours daily 7 days per week, which is 1440 hours, and it was determined that these services would be reduced to 12 hours daily 7 days per week, which is 720 hours from January 27, 2007 to March 27, 2007.

The petitioner's mother argued that the petitioner needs 24 hour daily skilled nursing services due to her fragile condition. She was previously in the hospital, and takes many medications. She provided a copy of a statement from

, stating that it is essential that the petitioner receive skilled home nursing service.

The physician that testified at the hearing agrees that the petitioner needs skilled home nursing care. He agrees with the pediatric physician's determination of reducing the skilled home nursing services from 24 hours daily to 12 hours daily. This takes into account the petitioner's mother's concern about coverage of care by providing a combination of skilled nursing services, home health aide services, care by her mother who does not work, and her father when he is home from work. After careful consideration, it is determined that the Agency's action to reduce the skilled home nursing services, is upheld.

DECISION

This appeal is denied and the Agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by

law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 3rd day of April, 2007,

in Tallahassee, Florida.

Stuart Imberman

Stuart Imberman
Hearing Officer
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Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-00580

PETITIONER,

Vs.

CASE NO. 1251392768

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Brevard
UNIT: 66394

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 1, 2007, at 1:05 p.m., in Cocoa, Florida. The petitioner was not present, but was represented by her son, . Her daughter-in-law, , was also present and testified on her behalf. Margaret Keogh, economic specialist II, represented the Department.

ISSUE

At issue is the action taken by the Department to deny the petitioner Institutional Care Program (ICP) Medicaid benefits to cover nursing home charges with hospice services at the nursing facility because her income exceeded the Program limits. The petitioner is seeking benefits for October and November 2006, and will have the burden of proof in this matter.

FINDINGS OF FACT

On December 27, 2006, the Department sent a Notice of Case Action to the petitioner's son informing him that Hospice Medicaid was approved for his mother effective December 2006. The notice also informed him that ICP and Hospice Medicaid for October and November 2006 were denied because the petitioner's income was more than the Program allowed to receive assistance. An Income Trust was set up but not funded with enough money in October 2006, and not funded at all in November 2006 (Respondent's Exhibit 1).

As part of the eligibility process, the Department must consider among other things, the petitioner's income. The petitioner's monthly income for October and November 2006 was Social Security of $1318, a pension from GM of $797, and $321.47 from New York State Electric & Gas Corporation (Respondent's Composite Exhibit 4). The petitioner's total income was $2,436.47. The maximum income limit for an individual under programs for institutional care and hospice was $1809 (Respondent's Exhibit 2).

The petitioner's representative was notified that in order to qualify for benefits, a qualified income trust should be established. It needed to be funded in the proper amount each month coverage was requested. The amount that needed to be funded each month coverage was requested, to allow for eligibility was $627.47. This amount was derived by subtracting $1809 from $2436.47. An Income Trust was established on October 10, 2006. A $500 deposit was made on October 11, 2006. The closing balance on October 26, 2006 was $500. On December 4, 2006, a $3000 deposit was made. No deposits were made in November 2006 (Respondent's Exhibit 5).

The Department denied ICP institutionalized Hospice Medicaid for October and November 2006, as the petitioner's income was greater than the Program limits. The qualified income trust fund was not sufficiently funded for those months, resulting in income outside of the trust being over the limit for eligibility. Although $500 was deposited in October, the amount that needed to be deposited into the qualified income trust to bring the petitioner under the income limit was $627.47.

The petitioner's representative did not know the process for securing benefits for his mother. He went to see a lawyer and set up the qualified income trust. His lawyer instructed not to let his mother's regular bank account get over $2000 each month. He explains that he received conflicting information from the Department and his lawyer. He believes that his worker told him not to touch the money in the regular account, or he would have funded the trust sooner. In December, he went back to see the lawyer and was instructed to make a deposit, which he did on December 4, 2006.

CONCLUSIONS OF LAW

Fla. Admin Code 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria, states in part:

> 1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.
> (f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for

institutional hospice services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(14)(a), F.A.C.

Fla. Admin. Code 65A-1.702 Special Provisions states in part:

(15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Department's Fla. Integrated Pub. Policy Manual, 165-22, Appendix A-9, April 2006, set forth the ICP income limit at $1809 for an individual for the time period at issue.

The Department's Fla. Integrated Pub. Policy Manual, passage1840.0110 Income Trusts (MSSI) states:

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate...If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;

2. it is irrevocable;

3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and

4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

> The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.
>
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**
>
> The Economic Self-Sufficiency Specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)
>
> Once the District Legal Counsel returns the income trust transmittal through the District Program Office, the Economic Self-Sufficiency Specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

The Department informed the petitioner's representative to establish and fund a qualified income trust, as the petitioner's income exceeded the institutionalized Hospice and ICP Program eligibility limits. The above authorities set forth that a sufficient amount of income must be placed in the trust for each month that eligibility is to be determined, in the month that the income is received, to reduce the countable income. The amount of monthly income not placed in the qualified income trust must be compared to the institutionalized Hospice and ICP income limit.

The Findings show that the petitioner had monthly income of $2436.47. The institutionalized Hospice and ICP income limit was $1809 for an individual. The findings show that for October 2006, the petitioner had income, outside of the qualified income trust, of $1936 to compare to the income limit. For November 2006, the petitioner had income of $2436.47, outside of the qualified income trust, to compare to the income limit.

The hearing officer finds that since no deposits were made to the income trust in November 2006, and insufficient funds were deposited in October 2006, the Department correctly denied ICP institutionalized Hospice Medicaid eligibility for those months.

DECISION

The appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 12nd day of April, 2007,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-0319

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 27, 2007, at 11:40 a.m., in Miami, Florida. The petitioner, , was present and represented himself at the hearing. The agency was represented by Mara Perez, senior human service program specialist for the Agency for Health Care Administration (AHCA) and Karinna Dadza, program specialist with AHCA. Appearing telephonically, as witnesses for the agency was Jason Ottinger, medical services program analyst and Robert Fifer, Ph.D., consultant for AHCA.

ISSUE

The petitioner is appealing the agency's November 29, 2006 denial of services by the Medicaid Program, of a prior authorization request for repair or replacement of cochlear implants. Specifically, the petitioner is requesting authorization for an "upgrade for the nucleus freedom speech processor." The reason for the denial is "not medically necessary." The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is a beneficiary of the Florida Medicaid Program. On October 5, 2006, a prior authorization request was submitted to the Agency for Health Care Administration, for cochlear implants repair and replacement for the petitioner. The provider was requesting an upgrade for the nuclear freedom speech processor. This request requires a prior authorization and along with the claim the submission of certain documentation such as, the manufacturer's invoice on the actual cost of the service; the manufacturer type of the cochlear implant; the reason for the repair or replacement; and documentation that manufacturer's warranty is still in effect.

On the prior authorization request submitted by the provider, the section requesting the explanation of necessity for the procedure only states that they are requesting an upgrade for the nucleus freedom speech processor at $6,850.

On November 29, 2006, the agency denied the request for the upgrading of the processor, as the petitioner currently has a cochlear implant processor that is functioning. Based on the information submitted, the replacement due to upgrading the processor was not considered to be medically necessary. Notification of the denial was provided to the petitioner.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

Fla. Admin. Code 59G-1.010 (2006) provides the following definitions and states as follows:

> (57) "Covered services" are those medical or allied care, goods, or services determined by the department to be eligible for reimbursement pursuant to Medicaid program standards, and those Medicaid and other medical or allied care, goods, or services that a prepaid health plan contractor agrees to furnish under the terms of its contract with the department. Also see "Medicaid services."
>
> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

The Florida Medicaid Hearing Services Coverage and Limitations Handbook (2006), states as follows:

> *Description*- Cochlear implant services provide restoration of auditory capacity to Medicaid eligible recipients with hearing loss that is not improved through the use of a hearing aid.
>
> *Service Components*- Components of the cochlear implant service include the implantable electrode array, the wearable speech processor and related components provided by the physician, postoperative computerized tuning of the headset, repairs and replacement. ...
>
> *Prior Authorization*- The physician who performs the cochlear implant procedure must obtain prior authorization from Medicaid before providing the implantation.

The petitioner states that he realizes that "the correct paper work was not submitted." However, he feels that he had nothing to lose by requesting a hearing and feels that the equipment is constantly broken. He feels that the new processor will better withstand the humidity in south Florida and not break down as often. The petitioner states that the processor is affected by his perspiration for which he has received treatment.

The agency responded by stating that there was no submission of information on breakdown of the processor, only requested an upgrade.

After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer finds that Medicaid under their current rules and policy

and the documentation provided, was correct in denying the prior authorization request for an upgrade of the processor.

DECISION

The appeal is denied as stated in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 9th day of April, 2007,

in Tallahassee, Florida.

A. G. Ramos
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01689

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 07 Brevard
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 11, 2007, at 10:35 a.m., in Cocoa, Florida. The petitioner was present, but was represented by his mother, [redacted]. His grandfather, [redacted], was also present. Lissette Knot, human services program specialist, Agency for Health Care Administration (AHCA), was present and represented the Agency. Appearing by telephone as witnesses for the respondent were: Rita Hines, contract manager; Diane Majcher, M.D., First Health Services; Anne Marie Gersch, RN; Barbara Butler-Moore and Lydia Baugh, notary, AHCA.

ISSUE

At issue is the action taken by AHCA to partially approve a prior authorization request for continued services under the Statewide Inpatient Psychiatric Program

(SIPP). Certification for hospitalization beyond March 2, 2007 was found not to be medically necessary. The Agency holds the burden of proof in this matter.

FINDINGS OF FACT

On August 24, 2006, the petitioner was admitted to the

r for psychiatric inpatient services. This is a mental health service that requires prior authorization. Proviso language adopted by the Florida State Legislature in May 2002 requires AHCA to adopt a prior authorization process using a targeted utilization management approach (Respondent's Composite Exhibit 1). First Health Services, Inc. is the contracted agency that determines medical necessity of prior authorization requests for AHCA. On behalf of AHCA, First Health Services performs all SIPP admissions and continued stay reviews of services provided to Medicaid recipients under the age of 18 years old.

The petitioner received continuous services under the Statewide Inpatient Psychiatric Program (SIPP) from his admission until December 5, 2006. After a physician review, his stay was extended until January 4, 2007. On December 13, 2006, a letter was sent informing the petitioner's mother and his hospital stay was certified as medically necessary for 27 more days, or until January 31, 2007. Certification beyond that date was not found to be medically necessary because "the needs of the recipient as described to us do not appear to require inpatient hospitalization, because available information indicates that treatment needs could be met at a lower level of treatment, available information indicates that the symptoms on admission have been stabilized and residual chronic symptoms are unlikely to improve significantly with continued SIPP treatment" (Respondent's Exhibit 4).

The purpose of SIPP is for short-term patient residential treatment for children under 18 years of age. According to First Health Services Manual, Utilization Management Procedures for Statewide Inpatient Psychiatric Programs, June 1, 2006, the Respondent's Exhibit 6, the goals of SIPP are: stabilization of presenting problems and symptoms and adequate resolution to allow safe return of the child to the family and community, reduction of recidivism of admission into acute psychiatric or SIPP services by providing aftercare services and/or linkages with appropriate community services; and the design of aftercare treatment plans that can be effectively implemented.

The Respondent's Exhibit 7, Selected Medical Records, contains the petitioner's information, provider information, diagnoses, medications, treatment history, mental status exam results, clinical data, among other information and documents. The multidisciplinary notes from August 24, 2006 through September 12, 2006, indicate that the petitioner's primary diagnosis was conduct disorder. The axis diagnoses include attention deficit hyperactivity disorder, bipolar disorder, manic-depressive psychosis, and severe problems with primary support group and problems related to the social environment. He was verbally impulsive and attention seeking, tried to manipulate staff and not listen to them, instigated peers by teasing and arguing, excessive talking, grabbing, and wandering. He had physical altercations with peers and needed constant redirections. The doctor noted that he was working on expressing his needs appropriately, and will be monitored for inappropriate sexual behaviors. He was adjusting to the structure and denied being verbal or physical to the staff. The petitioner was engaged in treatment for his conduct, individual therapy, family therapy, attending group meetings where he was participating in conflict resolution and social skills. He

did well in class when he was on task. He was easily distracted. During this time period, his anticipated discharge date was December 1, 2006. His discharge plan was to go home with safety measures in place to include a safety plan and door alarms. His recommended services included individual and family therapy, and medication management, improvement in his mood and no sexual inappropriate behaviors.

On September 13, 2006, the petitioner was approved for 21 additional inpatient days for meds and stabilization, as he was aggressive, labile, impulsive, grabbing staff, and poor boundaries and requiring a lot of redirection. At this time, he still had a psychiatric condition, his rating on the DSM IV Axis V continued to be fifty or less for the primary diagnosis, he was a threat to himself or others, had impaired thoughts, severely dysfunctional patterns, and services could reasonable be expected to improve his condition or prevent regression.

The petitioner received continuing hospitalization certification for 33 days from September 1, 2006 through October 3, 2006. He again received continuing hospitalization certification for 21 days for October 4, 2006 to October 24, 2006. Clinical Data for these time periods show the petitioner was disruptive and needed multiple redirections, demonstrated poor boundaries, instigated his peers, and was defiant. The doctor noted that he was still having some difficulty controlling his impulses and at times he was disruptive and verbally aggressive, however he was able to accept redirections. He was working on his social interaction with his peers, and had some medication changes. He was participating in his course of treatments including individual therapy, and participating in social skills and anger management. He was in specialized sexual abuse counseling and abusive reactive therapy. His discharge plan and discharge date

did not change. At this time, he still had a psychiatric condition, his rating on the DSM IV Axis V continued to be fifty or less for the primary diagnosis, he was a threat to himself or others, had impaired thoughts, severely dysfunctional patterns, and services could reasonably be expected to improve his condition or prevent regression.

The petitioner exhibited more of the same behaviors in the clinical data progress notes from October 19 through November 9, 2006. He was disruptive, verbally aggressive with frequent temper outbursts, and in need of multiple redirections and time outs. He was still engaged in treatment, individual therapy, family therapy, and community meetings, and needed direction in school work. The petitioner was approved for another 21 days for continued stabilization and therapies. Notice was sent that his stay was medically necessary from October 25, 2006 until November 14, 2006.

On November 16, 2006, the petitioner's mother and , were notified that the petitioner's continuing hospitalization had been certified as medically necessary for 21 days from November 15, 2006 to December 5, 2006. The clinical data shows he was off task, talkative, bossy and instigating peers, acted arrogant when confronted and not remorseful, among other behaviors. He disclosed the extent of his previous sexual activities and was benefiting from his treatment. The petitioner received a Thanksgiving pass to go home for the holiday. He was granted another 30 day certification for the medical necessity of continued hospitalization to December 26, 2006. Dr. , a reviewing physician, notes on December 8, 2006, that the petitioner was still off task, talkative, bossy, and verbally abusive. He was sexually preoccupied, defiant, oppositional, impulsive, and aggressive. His notes states that "patient seems to have reached baseline functioning. Medicaid

reimbursement Criterion C is not met. Partial certification is recommended to allow for a smooth transition". The case was deferred to . due to the length of stay and the petitioner receiving the maximum benefit of treatment, and that he did not require structured residential placement to work through his remaining issues. He was approved for a continued stay to January 31, 2007.

A Reconsideration of the denial for services beyond January 31, 2007 was requested and conducted. The Reconsideration review partially reversed the previous determination to end inpatient treatment on January 31, 2007. Inpatient treatment was found to be medically necessary for an additional 30 days, from February 1, 2007 to March 2, 2007. On January 26, 2007, physician notes from , the reviewing physician for the reconsideration determination, reviewed hospital records and case review notes to make her determination. She noted the petitioner's diagnoses, medications, and that his last certified date was January 31, 2007. The petitioner was reported to continue to be aggressive and fight. He was reported to have sexual daydreams from a record of his therapy session. Partial approval of 30 days for the stabilization of the petitioner's symptoms and to allow for a smooth transition to his discharge was granted. "No further days can be approved as patient doesn't meet Criteria C for further SIPP hospitalization" (Respondent's Exhibit 5). On January 26, 2007, both the petitioner's mother and the treatment facility were sent notice of this decision. The notice indicated that the petitioner's needs do not appear to require inpatient service, because services were not expected to improve the petitioner's conditions, or prevent regression, and that the symptoms noted on admission have

stabilized and residual chronic symptoms are unlikely to improve significantly with continued SIPP treatment (Respondent's Exhibit 5).

The petitioner was discharged to his mother. She believes he was discharged prematurely. She does not believe he has the tools he needs to be successful. He is struggling with day to day living, he does not listen, and he is failing school, steals, and is more aggressive since being discharged. The petitioner's mother and grandfather were under the impression the petitioner would have to meet 80% of his goals before he was discharged.

..., the petitioner's treating therapist, ... notes that the petitioner only completed 69% of his treatment plan goals. In a letter dated March 2, 2007, he notes that the petitioner "continues to maintain the thought process that what he did was not wrong, maintains his level of risk at moderately-high". ... recommended counseling services with a therapist who has experience dealing with children with sexual behavior problems. The petitioner's family was cautioned about leaving the petitioner alone with other children, and advised to use door alarms and motion detectors. The petitioner would need continued medication management and in-home behavioral services (Petitioner's Exhibit 2).

The petitioner's Treatment Plan Review of January 22, 2007 shows the overall completion of his treatment goals. His treatment techniques include individual therapy, group therapy, medication management, activity therapy, family therapy, and a behavioral management program. His primary problem is conduct disorder. He competed 43% of his goals. His secondary problem is inappropriate sexual behavior

(Roadmaps Track). He completed one out of eight short-term objectives/therapeutic interventions, or 12.5%. Another secondary problem is impulse control problems. He completed one out of five objectives, or 20% (Petitioner's Exhibit 1).

The Petitioner's Exhibit 3 is the discharge criteria, an after-care plan with a discharge summary, and obstacles to discharge prepared at by his therapist, The discharge criteria includes complying with the limits set by authority figures, mood, behavior, and thoughts stabilized sufficiently to independently carry out his basic self-care, no exhibition of sexually inappropriate behavior, no violent outbursts of temper, a completed safety plan to handle sexual thoughts and feelings, and improved control over urges and impulses. notes the petitioner should not be left alone with other children his age, or left in charge of younger children. He recommended that he continue to receive weekly individual therapy, family therapy at least every other week, medication management, and continue his education and follow through with the goals in his IEP. His teacher should be notified that he should not go to the bathroom with other children, even though he is less of a risk at school than at home. opines that the petitioner "remains a high risk of reoffending and is being discharged prematurely". notes that the petitioner is receiving services from when they show up.

CONCLUSIONS OF LAW

Florida Administrative Code 59G-4.050. sets the guidelines for compliance for providers and states:

> (1) This rule applies to all community mental health services providers enrolled in the Medicaid program.

(2) All community behavioral health services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook, October 2004, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Fla. Admin. Code 65A 1-702 defines SIPP as:

(16) Statewide Inpatient Psychiatric Program (SIPP) waiver. This program provides inpatient mental health treatment and comprehensive case management planning to enable discharge to less restrictive settings in the community for children under the age of 18 who are placed in an inpatient psychiatric program. Those who are Medically Needy and those who are Medicare recipients are excluded from this program. Services must be received from a designated provider selected by AHCA. This program provides an exception to provisions that residents of an institution for mental disease (IMD) are not eligible for Medicaid.

The Code of Federal Regulations at 42 C. F. R. 441.152 Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs states:

Certification of need for services.
(a) A team specified in Sec. 441.154 must certify that--
(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
(b) The certification specified in this section and in Sec. 441.153 satisfies the utilization control requirement for physician certification in Sec.Sec. 456.60, 456.160, and 456.360 of this subchapter.

AHCA/First Health Services Manual, June 1, 2006, defines Utilization Management for the SIPP and states:

Each admission must be prior approved by an independent team that includes a physician advisor not employed by the program. Admissions must be reviewed regularly to ensure that a child continues to meet medical necessity for this level of care and is receiving active treatment, as defined in Code of Federal Regulation, CFR 441.151.

The SIPP Program includes the following utilization management components:
1) Prior authorization of all Medicaid SIPP admissions.
2) Continued stay reviews conducted for all Medicaid SIPP admissions: at least every twenty-one (21) days for children under 10 years of age and at least every thirty (30) days for children ages 10 years and older.
3) On-site annual reviews to evaluate medical necessity criteria and quality of care.

In summary, the SIPP waiver permits Florida's Medicaid Program to:

1. provide specialized psychiatric residential inpatient diagnostic and active treatment services to high-risk recipients under age 18;
2. provide utilization management to ensure appropriateness of admission, length of stay, quality of care; and
3. reduce recidivism by providing or facilitating aftercare services and/or linkages with appropriate community services.
The manual also states:

Estimated Length of Stay and Discharge Planning
At each continued stay review, the facility should address the estimated length of stay for the recipient and plans for discharge. There should be basic agreement regarding length of stay and the anticipated date of discharge.
At each continued stay review, the facility should address the anticipated placement for the child or adolescent upon discharge, the identified support services needed upon discharge and the current status of referral and/or linkage to those services.

On page 27 of First Health Services' Manual, it describes Criteria C for SIPP continued stay. It states:

C. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).
1. The treating SIPP facility has developed a plan for continuing treatment illustrating the required intensity of services available at a SIPP level of care.
2. The treating SIPP facility has provided a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan was initiated as soon as the initial assessment was completed and included discrete, behavioral, and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.

3. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued SIPP hospitalization would be required or would result in regression.

The petitioner was an inpatient resident at [redacted] from August 24, 2006 to March 2, 2007. Medicaid paid for the stay as medical necessity was determined during that time frame. To participate in the SIPP Medicaid Waiver Program, certain criteria must be met. One of the criteria in the federal regulation and the agency's interpretive manual is that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed, and return them to the community. The petitioner was an inpatient for more than six months. Two reviewing physicians noted that the petitioner did not meet all of the requirements of "Criteria C", he had met his baseline goals, and would not benefit from an inpatient setting any longer. Recipients are stepped down to lesser services as soon as they are able. Medical necessity was not determined for any additional time after March 2, 2007.

The petitioner's mother argues that her son was released prematurely. She believed he had to meet 80% of his goals before being discharged. He had only met 69% when he was discharged. His treating therapist believed he was being discharged prematurely, and there was a moderately high risk that he would reoffend. Treating physician's testimony typically bears more weight than non-treating physicians. Although the petitioner's therapist believes he was discharged early, he did not provide an explanation or medical evidence of how keeping the petitioner in the SIPP would improve his conditions or prevent regression and thereby meet the above requirement

for continued payment by Medicaid. The therapist did not indicate an awareness of the Agency's SIPP Medicaid Waiver Program limitations. The therapist outlined his after care in a discharge summary that the necessary therapies could be conducted by community sources.

After careful consideration of the testimony, evidence, and the above cited rules, the hearing officer finds that the reviewing physicians correctly applied the medical evidence to the legal authorities that control the SIPP Medicaid Waiver Program and therefore the action to deny a prior authorization for a continued stay under the SIPP Medicaid Waiver was justified. It is concluded that medical necessity, as defined in the above authorities, was not demonstrated for Medicaid's continued payment under the SIPP Medicaid Waiver Program. While there was an allegation that 80% of the patient's goal must be met before Medicaid would no longer pay for the inpatient care, the legal definition of medically necessary did not include such.

DECISION

The appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 27th day of April, 2007,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01424

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 22, 2007, at 2:33 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's father, [redacted] Also present on behalf of the petitioner was the petitioner's mother, [redacted] Present as a witness for the petitioner was [redacted], nurse from the petitioner's provider agency. The Agency was represented by Erica Woodard, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Galgderan Silvaneto, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was Teresa Ashey, review operation supervisor from KePRO. KePRO is located in Tampa, Florida.

ISSUE

At issue is the Agency's reconsideration action of February 28, 2007, to reduce the petitioner's request for continued private duty nursing services from 1,080 hours of the service to 720 for the period of February 27, 2007 through April 27, 2007. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about five months of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "Agency". The petitioner has a twin, who additionally receives services through AHCA. The petitioner's representative had requested hearings for both children.

KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on February 15, 2007, that the petitioner's request for continued 1,080 hours of private duty nursing was going to be denied/reduced to 0 hours for the period of February 27, 2007 through April 27, 2007. The Agency's witness indicated that after review of the information provided to KePRO, from the petitioner's representatives, did not indicate a need for the level or amount of skilled nursing services for the petitioner.

A reconsideration was requested. After review by the Agency for this reconsideration process; the Agency changed the original decision and allowed for 720

hours of the private duty nursing care for the petitioner starting February 27, 2007. The petitioner requested a timely hearing and the previously approved benefits of 1,080 hours of private duty nursing were reinstated.

The Agency witness indicated that the petitioner's reason for the reduction of service is partially based on the petitioner's mother's ability to care for the petitioner during part of the day and that some nursing services for the petitioner's twin brother overlap.

The petitioner's representative indicated that the petitioner's mother will be returning to her full time employment in one week from this hearing date. The Agency advised the petitioner's representative to provide this new information to the provider so a new determination of service can be made by the Agency.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...

Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary.

The Agency, through KePRO, took action on reconsideration on February 28, 2007 to reduce the petitioner's request for continued private duty nursing services from 1,080 hours of the service to 720 for the period of February 27, 2007 through April 27, 2007. The Agency had originally reduced the private duty nursing hours to 0 hours. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representative disputed the Agency's decision to reduce private duty nursing service for the petitioner even after the reconsideration change. He argued that based on how the nursing service provider provides the service for the petitioner and his brother; there would be too much time in the day were the necessary nursing service would not be provided to either. He also argued that his wife, the petitioner's mother, will be returning to full time employment in a week and the petitioner is in need of private duty nursing at least as many hours of the requested amount. The respondent explained that the petitioner can inform the provider of the mother's impending employment and another decision on benefits will be made based on verified employment.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action on reconsideration of February 28, 2007, to reduce the petitioner's request for continued private duty nursing services from 1,080 hours of the service to 720 for the period of February 27, 2007 through April 27, 2007.

DECISION

This appeal is denied and the Agency's action affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 27th day of April, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished T

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01423

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 22, 2007, at 2:33 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was present, but was represented at the hearing by the petitioner's father, Also present on behalf of the petitioner was the petitioner's mother, Present as a witness for the petitioner was , nurse from the petitioner's provider agency. The Agency was represented by Erica Woodard, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Galgderan Silvaneto, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was Teresa Ashey, review operation supervisor from KePRO. KePRO is located in Tampa, Florida.

ISSUE

At issue is the Agency's action of February 15, 2007, to reduce the petitioner's request for continued private duty nursing services from 600 hours of the service to 480 for the period of February 27, 2007 through April 27, 2007. The reduction is from 10 hours a day to 8 hours a day of the above service. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about five months of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "Agency". The petitioner has a twin, who additionally receives services through AHCA.

KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on February 15, 2007, that the petitioner's request for continued 600 hours of private duty nursing was going to be denied/reduced to 480 hours for the period of February 27, 2007 through April 27, 2007. The Agency's witness indicated that after review of the information provided to KePRO, from the petitioner's representatives, did not indicate a need for the level or amount of skilled nursing services for the petitioner. The petitioner requested a timely hearing and the previously approved benefits of ten hours a day of private duty nursing were reinstated.

The Agency witness indicated that the petitioner's reason for the reduction of service is partially based on the petitioner's mother's ability to care for the petitioner during part of the day and that some nursing services for the petitioner's twin brother overlap.

A reconsideration was requested, but the Agency upheld the original decision.

The petitioner's representative indicated that the petitioner's mother will be returning to her full time employment in one week from this hearing date. The Agency advised the petitioner's representative to provide this new information to the provider so a new determination of service can be made by the Agency. The Agency witness, after listening to relevant testimony from the petitioner's representative, indicated that if the petitioner requests it; a home health aide may be provided to the petitioner for six hours, when the private duty nursing benefits is not provided to the petitioner.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care,

be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...

Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary.

The Agency, through KePRO, took action on February 15, 2007 to reduce the petitioner's request for continued private duty nursing services from 600 hours of the service to 480 for the period of February 27, 2007 through April 27, 2007. The reduction amount, considered on a daily basis, is from 10 hours a day to 8 hours a day of the

service. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representative had agreed with the Agency witness that he could accept the offer of six hours of a service aide being provided to the petitioner. He, none the less, still disputed the Agency's decision to reduce private duty nursing service for the petitioner. He argued that based on how the nursing service provider provides the service for the petitioner and his brother, there would be too much time in the day were the necessary nursing service would not be provided to either. He also argued that his wife, the petitioner's mother, will be returning to full time employment in a week and the petitioner is in need of private duty nursing at least as many hours of the requested amount. The respondent explained that the petitioner can inform the provider of the mother's impending employment and another decision on benefits will be made based on verified employment.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action of February 15, 2007, to reduce the petitioner's request for continued private duty nursing services from 600 hours of the service to 480 for the period of February 27, 2007 through April 27, 2007.

DECISION

This appeal is denied and the Agency's action affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for

Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 27th day of April, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01044

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 10 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 16, 2007, at 10:25 a.m., at the Sony Service, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's foster mother, . The Agency was represented by Helena Glassberg, program administrator, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the agency was Teresa Ashey, review operation supervisor from KePRO. was present as an observer (via the telephone). KePRO is located in Tampa, Florida.

ISSUE

At issue is the agency's action of January 17, 2007, to deny the petitioner's request for home health aide services from 240 hours of the service to 0 hours of the service for

the period of December 10, 2006 through February 7, 2007. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about fifteen years of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "Agency".

KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on January 17, 2007, that the petitioner's request for 240 hours of home health aide service was going to be denied/reduced to 0 hours for the period of December 10, 2006 through February 7, 2007. The Agency's witness indicated that after review of the information provided to KePRO, from the petitioner's provider, did not indicate a need for the home health aide services for the petitioner. The petitioner requested a timely hearing and the previously approved benefits of home health aide were reinstated.

A reconsideration of the above decision was requested. The reconsideration review upheld the original denial of the requested services.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...

The Agency, through KePRO, took action on January 17, 2007 to deny the petitioner's request for home health aide services for 240 hours of the service to 0 hours of the service for the period of December 10, 2006 through February 7, 2007. This decision was based on the information as provided by the petitioner's service provider and the petitioner's medical necessity need of the request for the service.

The petitioner's representative argued that the petitioner has medical problems and is in need of the requested service. She additionally argued that she requested, herself, two hours a day of the service and not four as indicated by KePRO and the petitioner's provider. The respondent argued that the "provider" information as provided to KePRO is what the Agency relies upon in order to make their decisions. The Agency further argued that they had requested the petitioner's provider; provide additional information that could

possibly indicate the need for the service, but it was not provided to KePRO. The petitioner's representative indicated that she will contact the petitioner's provider and request a new and updated service request.

After considering the evidence, Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action of January 17, 2007 to determine that the petitioner's request for 240 hours of home health aide service was going to be denied/reduced to 0 hours for the period of December 10, 2006 through February 7, 2007, based on the petitioner's lack of medical necessity need of the request for the service.

DECISION

This appeal is denied and the Agency's action affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 16th day of April, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-0514

PETITIONER,

Vs.

CASE NO. 1012040887

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 66254

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 3, 2007, at 12:15 p.m., in Miami, Florida. The petitioner, ..., passed away on January 10, 2006. Present on her behalf, was , director of admissions for .... Nursing Home and ., former nursing home administrator. The Department was represented by Oneya C. Mungarra, senior economic self-sufficiency specialist. Appearing as witnesses for the Department were, Oneida Gamboa, economic self-sufficiency specialist (ESSS); Enrique Bascuas, ESSS; and Byron Espinales, ESSS. This hearing was previously scheduled for February 28, 2007, but was continued at the request of both parties.

ISSUE

The petitioner is appealing the Department's actions of June 8, 2006, January 30, 2006 and November 7, 2005, where applications for Institutional Care Program (ICP) benefits are denied.

FINDINGS OF FACT

Prior to addressing the merits of the case, it is necessary to determine if a timely hearing request was made.

The petitioner was admitted to the nursing facility on October 4, 2005. On behalf of the petitioner, the facility filed an application for ICP Medicaid on October 5, 2005, which was processed by the Department and denied on November 7, 2005. The petitioner's representative (the facility) acknowledged receiving the denial and not requesting a hearing until June 2006.

On December 27, 2005, the facility again filed an application for ICP Medicaid on behalf of the petitioner. The application was processed by the Department and denied on January 30, 2006. The petitioner's representative acknowledges receiving the denial notice and not requesting a hearing until June 2006.

Florida Administrative Code sets time limits in which a hearing may be requested. The petitioner must request a hearing within ninety days from the date of the notice. In this case, the request for a hearing on the November 7, 2005 and January 30, 2006 denials, were made beyond the time permitted. Therefore, on the issue of both denials (November 7, 2005 and January 30, 2006), the appeal is dismissed.

On May 31, 2006, the facility filed an application for ICP Medicaid on behalf of the petitioner. This application was processed by the Department and on June 8, 2006, sent a denial notice stating the reason as, "you did not follow through in establishing eligibility. The petitioner's representative had requested the hearing in June 2006, but was not processed by the Department until January 2007. The hearing request was made to the Office of Appeal Hearings on January 19, 2007. The Department assumed responsibility for the delay. The hearing officer will then proceed to address the merits of the case, pertaining to the Department's June 8, 2006 denial of ICP Medicaid.

The petitioner's application was filed and received on May 31, 2006. On June 1, 2006, a general information notice was mailed to the petitioner informing them of required documents in order to determine eligibility.

On June 7, 2006, the case worker reviews the file and learns that the petitioner is deceased (January 10, 2006). The Department informed the representative that they would only be able to provide retroactive Medicaid eligibility to February 2006, given that the application was filed May 2006. The Department's policy allows for retroactive Medicaid for any one or more of the three calendar months, proceeding the application month. The representative was requesting eligibility for January 2006 and December 2005. The Department denied the application, based on policy that would not allow them to provide Medicaid eligibility beyond the three months retroactively. Notice was sent to the representative on June 8, 2006.

CONCLUSIONS OF LAW

Fla. Admin. Code, Section 65-2.045, refers to hearing requests and states in part:

(3) A Request for Hearing may be made by the applicant/recipient or someone in his/her behalf. However, if the appeal is filed by someone other than the applicant/recipient, attorney, legal guardian, spouse, next of kin, the grantee relative in cash assistance, or a person allowed by the Department as an authorized representative to participate in the eligibility determination, the person making the appeal must have written authorization of the applicant/recipient. Such written authorization must accompany the Hearing Request. Should the request be filed without the written authorization, the authorization must be provided in response to a request from the Department or hearing officer, prior to the appeal going forward. Without prior proper written authorization, the Department will treat a request for hearing as being made by someone not authorized to do so. Therefore, the appeal will be dismissed.

Fla. Admin. Code, Section 65-2.046, sets forth time limits in which to request a hearing and states in part:

(1) The applicant or authorized representative must exercise their right to appeal within 90 calendar days in all programs.

Fla. Admin. Code, Section 65-2.047, states that a request is to "be rejected by the hearing officer", when the request "is not filed within the time limits as provided in 65-2.046."

Fla. Admin. Code, Section 65A-1.702 Special Provisions states in part:

(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.

(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility.

The representative stated that they thought that they could continue seeking eligibility with the past applications and were requesting eligibility for December 2005 and January 2006.

Based on the above mentioned authorities, it is concluded that the Department's action of June 8, 2006, to deny ICP Medicaid eligibility beyond the retroactive months was correct.

DECISION

The appeal is denied and the Department's action is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of April, 2007,

in Tallahassee, Florida.

A. G. Ramos
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-00262

PETITIONER,

Vs.

CASE NO. 1252298803

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88322

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 6, 2007, at 11:22 a.m., in Lake Worth, Florida. The petitioner is deceased. Representing the petitioner was , attorney. Appearing as a witness was , designated representative for the Medicaid application. Representing the Department was Terry Verduin, attorney, District 9 Legal. Appearing as a witness was Chuck Maikkula, specialist II.

ISSUE

At issue is whether the Department was correct in denying an application for Institutional Care Program (ICP) Medicaid benefits due to the petitioner's assets exceeding Program eligibility limits. Specifically, did the durable power of attorney (DPA) exceed their authority and purchase a personal service contract (PSC) with existing funds? The representative is seeking retroactive benefits for October 2006.

FINDINGS OF FACT

The petitioner was admitted to a nursing facility September 9, 2006. On September 28, 2006, a durable power of attorney was established and notarized. The petitioner passed away October 28, 2006.

Subsequently, the nursing facility submitted an application for Institutional Care Program (ICP) Medicaid benefits November 8, 2006, seeking retroactive eligibility for the month of October. As part of the eligibility determination process, the Department must consider, among all factors, the petitioner's assets.

The petitioner's bank account on September 29, 2006, had a total of $56,774.77. From this account $27,300 was withdrawn to purchase a Personal Service Contract (PSC). The PSC is mostly medical in nature. This means that the contract is to be used for medical assistance considerations.

The Department explains that based upon the Florida Statute at 708.08, and in particular section 7, the DPA cannot purchase a PSC because no authority was given to make that specific purchase. Because the funds used to make the purchase could have been used for the medical treatment at the nursing facility, the purchase of the PSC was made without the consideration for ICP eligibility.

Lastly, the Department explains that the DPA mostly discusses use of income and not assets. For example, section 5 of the DPA discusses the use of income for the purpose of purchasing a Qualifying Income Trust or Irrevocable Income Trust for Medicaid eligibility.

Because the DPA is not specifically allowed to purchase a PSC, the Department denied the application.

The representative, citing sections 1, 4, and 6 of the DPA, explains the DPA gives the authority, in general, to "exercise and perform any act", to "conduct, engage in, and transact any and all lawful business", and to "make, receive, sign, endorse, execute...and possess such applications, contracts, and agreements..." In other words, the DPA may conduct all business as if it were the petitioner. This would include the purchase of the PSC in question.

The DPA has to take care of all things, to include applying for ICP. Because there are so many types of contracts, it would not be feasible to list them all.

CONCLUSIONS OF LAW

Fla. Stat. ch. 709 (2006) states is part:

709.08 **Durable power of attorney.**--

(1) CREATION OF DURABLE POWER OF ATTORNEY.--A durable power of attorney is a written power of attorney by which a principal designates another as the principal's attorney in fact. The durable power of attorney must be in writing, must be executed with the same formalities required for the conveyance of real property by Florida law, and must contain the words: "This durable power of attorney is not affected by subsequent incapacity of the principal except as provided in s. 709.08, Florida Statutes"; or similar words that show the principal's intent that the authority conferred is exercisable notwithstanding the principal's subsequent incapacity, except as otherwise provided by this section. The durable power of attorney is exercisable as of the date of execution; however, if the durable power of attorney is conditioned upon the principal's lack of capacity to manage property as defined in s. 744.102(12)(a), the durable power of attorney is exercisable upon the delivery of affidavits in paragraphs (4)(c) and (d) to the third party.

The submitted Durable Power of Attorney (Petitioner's Exhibit 1) is a legitimate document.

(7) POWERS OF THE ATTORNEY IN FACT AND LIMITATIONS.--

(a) Except as otherwise limited by this section, by other applicable law, or by the durable power of attorney, the attorney in fact has full authority to perform, without prior court approval, every act authorized and specifically enumerated in the durable power of attorney.

(c) If such authority is specifically granted in the durable power of attorney, the attorney in fact may make all health care decisions on behalf of the principal, including, but not limited to, those set forth in chapter 765.

In this instant case, the purchase of a personal service contract was not specifically enumerated in the DPA. The submitted DPA concerned itself, among all items, with financial instruments (such as notes, bonds, CDs, etc.) and insurance policies of all forms to include health insurance.

As required by (7)(c) there must be the granting of the DPA to make all health care decisions on behalf of the principal. This is not enumerated in the DPA.

There are rules that must be adhered to when applying for Medicaid benefits. As these rules are spelled out in Federal Regulations as well as State Statute, it must be specifically noted for any DPA to follow. It cannot be done in generalities.

The hearing officer, therefore, agrees with the Department's action because the DPA was not specific as to the exercise of making health care decisions or specific in allowing for the purchase of a PSC.

DECISION

The appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 8th day of March, 2007,

in Tallahassee, Florida.

Melvyn Littman

Melvyn Littman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-00351

PETITIONER,

Vs.

CASE NO. 1249710511

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Clay
UNIT: 88250

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 22, 2007, at 10:15 a.m., in Green Cove Springs, Florida. The petitioner was not present. However, he was represented by his power of attorney, mother, appeared as a witness. The Department was represented by Amanda Everington, economic services self-sufficiency specialist supervisor and Selena Simpkins, public assistance specialist.

ISSUE

At issue is the Department's action of December 8, 2006 to deny Institutional Care Program (ICP) Medicaid benefits for October 2006, due to excess income. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner's representative submitted an application for ICP Medicaid on September 27, 2006. The maximum income limit to receive ICP Medicaid is $1809. The petitioner's income consisted of $1948.50 in Social Security benefits. The petitioner's income was not disputed. Since the petitioner's income exceeded the maximum income limit, an income trust had to be set up and properly funded before the petitioner could be approved for ICP Medicaid benefits.

The petitioner's representative established a Qualified Income Trust on November 8, 2006 and funded it on November 15, 2006 (Respondent's Exhibits 1 and 2). Since the petitioner's income was below the maximum income limit, ICP Medicaid was approved for November 2006 and ongoing. All parties acknowledged at the hearing that during the month of October 2006, the income trust had not been properly funded and as a result, the petitioner's income was over the ICP Medicaid income limit of $1809. As such, ICP Medicaid was denied for the month of October 2006 due to excess income.

The petitioner's representative acknowledged that he had not carried out his responsibility to establish and properly fund the income trust required to achieve ICP eligibility. Neither party was aware of any policy rule, regulation or law that would be applicable to make an exception to the ICP income requirement.

CONCLUSIONS OF LAW

The argument of the petitioner's representative was that the petitioner should not be adversely affected due to his failure to properly establish and fund an income trust for October 2006 as required by policy. The argument of agency staff was that all policy

criteria must be fulfilled before ICP Medicaid benefits can be authorized and there are no provisions in the agency policy to make exception to meeting such criteria.

Fla. Admin. Code 65A-1.702 **Special Provisions** (15) "Trusts" in part states:

> (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).
>
> (b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.
>
> (c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income."

Fla. Admin. Code **65A-1.713 SSI-Related Medicaid Income Eligibility Criteria**, in part states:

> "(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(13)(a), F.A.C."

The Department published Transmittal number I-06-03-0006 on March 10, 2006 which includes Appendix A-9 to the Department's Integrated Policy Manual, 165-22 for the time period at issue. This chart sets forth the ICP income limit for an individual at $1809, effective April 2006.

Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 further states:

> "Income Trusts (MSSI)
> The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:
>
> It is established on or after 10/01/93 for the benefit of the individual;
> It is irrevocable;
> It is composed only of the individual's income (social security, pensions, or other income sources); and
> The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.
>
> The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested**. (emphasis added)"

The above authorities provide for the establishment of an income trust by an Institutional Care Program applicant in order to reduce monthly income below the state

income limitations. The petitioner's income exceeded the maximum income limit for ICP Medicaid of $1809 during the month of October 2006. The Findings of Fact show that an income trust was established and properly funded in November 2006, thereby reducing the petitioner's income to below the maximum income limit for the ICP Medicaid Program.

Since the petitioner's income for October 2006 exceeded the maximum limit, the Department denied ICP Medicaid benefits for that month. The Department's action is consistent with the above cited authorities and there were no grounds presented to make an exception to this policy.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 5th day of April, 2007,

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01394

PETITIONER,

Vs.

CASE NO. 1249061270

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Okaloosa
UNIT: 88176

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 20, 2007, at 10:30 a.m., in Ft. Walton Beach, Florida. The petitioner has passed away, but was duly represented by his son, . Testifying on behalf of the petitioner was his daughter-in-law, . The Department was represented by Jon Ann Painter, economic self-sufficiency specialist I.

The hearing record was held open for 10 days, or until March 30, 2007, to allow the Department to submit additional evidence which was received and entered as Respondent's Exhibit 5.

ISSUE

The petitioner is appealing the Department's action of February 1, 2007 to deny Institutional Care Program Medicaid due to excess income. The petitioner bears the burden of proof.

FINDINGS OF FACT

Prior to applying for Institutional Care Program (ICP) Medicaid, the petitioner was living in an assisted living facility with his wife. On or about July or August 2006, the petitioner entered Delta Healthcare nursing home. An application for ICP Medicaid was submitted to the Department on the petitioner's behalf on September 13, 2006. Retroactive ICP Medicaid was requested for August 2006.

As part of the eligibility process, the Department must consider among other factors, the petitioner's income. The petitioner's monthly income is from Social Security of $610.50, Civil Service Annuity of $1,466, interest income of $2.14 and $.09 and $1,743 Veteran's Administration pension. The VA pension included $412.35 spousal amount, Aid and Attendance of $609, and $721.65 improved pension. The Department does not calculate the income designated for the petitioner's spouse or that portion of the income designated as Aid and Attendance in its determination of countable income. The petitioner's total countable gross income was $2799.88. The maximum income limit was $1809. The gross income received by the petitioner was more than the allowable income limit for ICP.

The nursing home assisted the petitioner in his application for ICP benefits. Based on their understanding of the petitioner's income and their belief that his entire VA benefit was Aid and Attendance and therefore excludable, the nursing home staff provided the petitioner's representative with an Irrevocable Income Trust document and advised him to fund it with an initial deposit of $500. The Irrevocable Income Trust was set up and funded on August 4, 2006. The petitioner's representative made subsequent deposits of $400 on September 7, 2006 and $500 on October 7, 2006. No further deposits were made to the Irrevocable Income Trust as the petitioner expired on November 3, 2006.

The Department acknowledged that it did not begin processing the application until November 20, 2006, after the death of the petitioner. The initial Irrevocable Income Trust was submitted to the District Legal Counsel for review and was returned for correction and amendment. The corrected Irrevocable Income Trust document was resubmitted on November 20, 2006 and was approved by District Legal Counsel on January 25, 2007.

The Department denied ICP Medicaid for August through November 2006, as the petitioner's income was greater than the Program Limits because the Qualified IncomeTrust (QIT) was not sufficiently funded. The petitioner's representative explained that he was never told the dollar amount that had to be put in the QIT each month and that he was under the impression that none of the Veteran's Pension would have counted. Had he been advised by either the Department or the nursing facility

staff they would have funded it accordingly. The amount that needed to be funded was the difference between the petitioner's gross income of $2,799.88, minus the maximum income limit of $1809, or at least $991 per month.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(14)(a), F.A.C.

Fla. Admin. Code 65A-1.702 Special Provisions states in part:

> (15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Fla. Integrated Pub. Policy Manual, passage1840.0110 Income Trusts (MSSI) states:

> The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
>
> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they

set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;

2. it is irrevocable;

3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and

4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**

The Economic Self-Sufficiency Specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)

Once the District Legal Counsel returns the income trust transmittal through the District Program Office, the Economic Self-Sufficiency Specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

The Department's Transmittal Number P-05-11-0037 shows the ICP income limit for an individual at $1809 effective January 2006 and Transmittal I-06-03-0006, effective April 2006, shows the ICP income limit at $1809 for an individual.

The Department's Integrated Policy Manual,165-22, Section 1840.0906.02, Veterans Payments-Pensions, states in part:

> VA pensions are included as unearned income, excluding the amount of aid and attendance, housebound allowance, and unreimbursed medical expenses....

The petitioner is seeking ICP Medicaid coverage for August through November 2006. The Findings show that the petitioner's income exceeded the ICP income limit of $1,809 and that the QIT was not sufficiently funded to reduce the countable income to under program limits. According to the above authorities, the income limit was $1,809 effective January 2006. The petitioners argued that neither the Department nor the nursing home informed them of the amount necessary to adequately fund the trust to allow ICP eligibility. The undersigned could find no authority to grant an exception to exceeding the income limit for a month in which the QIT was not properly funded to bring the income under the limit. Therefore, the hearing officer concludes that the Department correctly denied the ICP for the months at issue due to income exceeding the ICP limit.

DECISION

The appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of April, 2007,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-00215

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 02 Liberty
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 21, 2007, at 10:45 a.m., in Marianna, Florida. The petitioner was present and was represented by his foster parents, and . The respondent was represented by Debbie Jamski, RNS, Agency for Health Care Administration (AHCA) Medicaid, Area 2B. Testifying on behalf of the Agency, via speakerphone, was Theresa Ashy, review operations supervisor, Keystone Peer Review Organization (KePRO) and Dr. Robert Buzzeo, medical director, KePRO.

ISSUE

The petitioner is appealing AHCA's action of December 13, 2006 to deny 80 hours Private Duty Nursing from a request of 1,440 hours to 1,360 hours for the months of December 7, 2006 thorough February 4, 2007 based on the contention that the

intensity or level of medical care requested was not medically necessary. The Agency bears the burden of proof.

FINDINGS OF FACT

The petitioner is 4 years of age (date of birth [redacted]) and is a Medicaid recipient. The petitioner's care is medically complex. The petitioner had been receiving private duty nursing services under Medicaid. A request for 1,440 hours of private duty nursing was submitted by the provider, Maxim Healthcare Services, for the period of December 7, 2006 through February 4, 2007.

The petitioner has resided with his foster mother and father since March 2005. Prior to the action under appeal, the foster parents were authorized to receive 24 hour/7 days a week private duty nursing care (PDN). The foster parents have not been utilizing the approved amount of private duty nursing care but have relieved the private duty nursing staff on holidays and other occasions and when nursing staff are not available. The foster parents have been providing 12 hours of care on Sundays.

The foster mother is a licensed practical nurse (LPN) employed full time Monday through Friday with the school board and the foster father works for the City of Bristol, Florida, as well as running his own consulting/contracting business for water/waste management from his home. He is on call and may be called away at any moment due to the requirements of his employment. There are no siblings living in the home, but the foster parents' daughter occasionally visits and assists with the petitioner's care. The petitioner has two half siblings who have been placed with other families. The foster

parents are the only caregivers available and trained to take care of the petitioner. They are not classified as Medical Foster Parents and are not paid to care for this child as such.

Requests for private duty nursing are reviewed with a contract provider who completes prior authorization for the requested service. That contract provider is KePRO. The request for services is submitted by the home health care provider, in this case, Maxim Healthcare Services. The requests are for 60 day time periods. All communication is sent between KePRO and the provider until a decision is reached. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. Once services, as in this case, were rejected or modified, a notice is sent to the recipient's family.

KePRO received the request for 1,440 hours of private duty nursing submitted by the provider, Maxim Healthcare Services. A Kepro Registered Nurse Reviewer (RNR) completed a screening of the Plan of Care submitted in December 2006. At AHCA's direction, the RNR used modified InterQual Criteria and a Pediatric Home Care Guide for Private Duty Nursing (PDN) Hourly Utilization to review the request for PDN services. Using that documentation, a Utilization Form was developed. The Utilization Form assigns point values to physical conditions of the petitioner and level of care that is anticipated. KePRO concluded that based on the points the petitioner was scored, a physician's review was required.

The case was then referred to a Board Certified Pediatric Specialty Physician Consultant. A Board Certified Pediatrician reviewed the case and made the following determination: "Patient diagnosis, clinical data, Plan of Care details, primary caregiver social support needs and detailed communication, supports PDN services for the certification period; however, Provider and foster mother should begin to work out a reasonable schedule of independent care especially on weekends when mother is available to care for the child. The first 30 days of the certification period provided for 24 hours/day/7 days week followed by 24 hours/day/Monday through Friday and 16 hours/day/Saturday and Sunday for the second half of the certification period (Respondent's Composite Exhibit 1, Section C)." The determination of the physician consultant was sent to Maxim Healthcare Services on December 13, 2006. Based on the documentation, the pediatric consultant denied 80 hours and approved 1,360 hours of the 1,440 requested hours of private duty nursing.

The documentation indicated a request for the petitioner with mucopolysaccharidosis (MPS) as a result of Hurlers Syndrome, a genetic disorder. He has also been diagnosed with esophageal reflux, intestinal infection due to clostridium difficile, enteritis due to adenovirus, acute myocardial infarction, yellow fever, bronchopneumonia, asthma, acute respiratory failure, hemorrhage of the gastrointestinal tract, spinal kyphosis and other respiratory distress insufficiencies. The petitioner is nonverbal, has a hearing deficit, tracheotomy and two failed stem cell implants. The petitioner requires frequent suctioning of his tracheotomy, approximately

every 5-8 minutes. He has an extremely complicated past medical history including two failed bone marrow transplants, frequent and recurrent respiratory infections, pneumonia, tracheitis, and Reactive Airway Disease. The petitioner often requires oxygen, especially at night. Total care is required for the child.

A request for a Reconsideration review was submitted to KePRO by Maxim Healthcare Services. For the Reconsideration, a second, different Board Certified pediatrician, Dr. Robert Buzzeo, reviewed the request on December 14, 2006. The determination by the second physician consultant was based both on the patient's clinical medical state and the social needs of the family as well as the level of intensity needed to provide for his care. The program is operated with the understanding that parents or caregivers will be able to participate in providing care as they are trained in providing for the child's care. KePRO determined it to be reasonable that the caregivers could provide at least eight hours of independent care especially on the weekends. Sixteen hours on Saturday and on Sunday was approved to allow some coverage during the evening so that the caregivers could sleep. On December 15, 2006, a KePRO representative sent a note to the physician consultant for clarification of approved hours and dates. On December 17, 2006, the second physician reviewer upheld the initial decision and authorized 24 hours per day 5 days per week Monday through Friday and 16 hours per day Saturday and Sunday for the 60 day certification period at issue. On December 18, 2006, the provider, Maxim Healthcare Services, submitted a statement indicating the primary caregiver accepted the final decision.

A hearing request was received by KePRO on January 5, 2007. As the request for Fair Hearing was not submitted within the ten day time frame from the date of the Reconsideration letter, administrative approval of 80 hours for the certification period was not restored. Subsequently, at the direction of AHCA, on January 10, 2007, KePRO placed Administrative Approval on the case of 80 hours to total 1,440 hours for the certification period December 7, 2006 through February 4, 2007.

The petitioner's foster parents do not agree with the decision by KePRO. At the hearing, the foster mother stated that it was difficult for the family to provide care, work and do other activities. The foster mother is concerned with the petitioner's medical needs, as the petitioner is so medically complex and has an extended tracheotomy which requires suctioning every 5 to 8 minutes. According to the foster mother, the presence of a nurse helps prevent hospital admissions and results in early discharge because nursing is in place. The mother is concerned as two people are needed when the petitioner is in crisis, the need to make medical decisions the administration and monitoring of medication. Although the primary caregiver, , has not utilized the authorized PDN of 1,440 hours in the past, she is concerned that her husband will not be able to help her when he is called away on his job. In addition, the primary caregiver is helping her father provide for the care of her mother who has Alzheimer's and has suffered a stroke. It is the foster mother's opinion that she needs access to help 24 hours per day, 7 days per week as she is working and help is needed.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

Florida Statutes § 409.919 Rules(2006) states:

> The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906, as they relate to these responsibilities, and any other provisions related to responsibility for the determination of Medicaid eligibility.

Florida Administrative Code at Fl. Admin. Code 59.G-1.010, **Definitions**, states for medical necessity:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The Home Health Services Coverage and Limitations Handbook defines private duty nursing (at page 2-15):

Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition.

The Home Health Services Coverage and Limitations Handbook , Chapter 2, p.2-16, states in part:

Parental Responsibility Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care that they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

The Home Health Services Coverage and Limitations Handbook , Chapter 2, p.2-16, states in part:

> Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.

The Home Health Services Coverage and Limitations Handbook provide that for private duty nursing, prior authorization must be received (at page 2-17):

> **Service Authorization:** All private duty nursing services must be prior authorized by a Medicaid service authorization nurse prior to the delivery of services.

In accordance with the provider manual (CMS 1500) prior authorization requests must be submitted by the provider (at 2-2):

> **Who Submits the Request** The request for prior authorization must be submitted by the provider who plans to furnish a service, except for out-of-state prior authorization.

As a result of the reduction in private duty nursing services paid for by Medicaid, the petitioner, through his representatives, appeal this action, asserting that 24 hours per day, seven days per week of private duty nursing services are necessary. In weighing the evidence, the following conclusion is reached by the undersigned: AHCA presented evidence from the pediatric physician consultant of the number of hours deemed medically necessary. This is a medical expert who routinely determines medical necessity for Medicaid services. The physician's statement submitted by the petitioner did not show that the petitioner's condition would deteriorate as a result of the current plan and indeed, as indicated by the petitioner's representative, the previously authorized PDN services of 1,440 hours had not been fully utilized either due to lack of available nurses willing to work or because the nurses were being allowed to take off for

holidays or vacations. The petitioner's physician does not routinely determine medical necessity for Medicaid services and are not as familiar with the term as used in the governing authorities, therefore, greater weight was given to the agency's expert witness.

In addition, the agency's Registered Nurse Specialist and two Board Certified Pediatric physicians who are considered medical experts, determined that the reduction of private duty nursing care is appropriate for the petitioner. The decision was based upon a review of the petitioner's clinical medical state and the social needs of the family. The respondent acknowledges that the petitioner is medically complex. However, according to the above authorities, private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. In addition, according to the above authorities, private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care.

The petitioner's statement that it was difficult for the family to provide care, work and do other activities was considered. The foster mother stated that the hours she worked and the petitioner's foster father needed to be on call, required 24 hour seven day per week PDN . The foster mother indicated that she provides care 12 hours on Sundays and that she has not been able to use the allotted amount of authorized PDN

services for various reasons. The evidence sets forth that the foster parents provide care 12 hours on weekends.

According to the above authorities, the agency is the final arbiter of medical necessity. In making the determination of medical necessity, the agency followed its procedure to have a professional registered nurse practitioners and the opinion of a physician as the reviewing physician. Such determination was based upon the information available at the time the goods or services were provided.

The petitioner's caretaker, who are his foster parents, play an important role and according to the above authorities, their involvement is strongly encouraged in taking care of him. The evidence submitted indicated that the caretakers have been providing care for the petitioner when private duty nurses were unavailable or for 12 hours on Sundays. After careful consideration, it is determined that the action to reduce the private duty nursing hours from 1,440 to 1,360 hours or from 24 hours per day, seven days per week to 24 hours per day, Monday through Friday and 16 hours per day on Saturday and Sunday, is in accordance with the above authorities.

Based on the above cited authorities, the respondent's action to deny 80 hours of private duty nursing for the period of December 7, 2006 to February 4, 2007 was within the rules of the Program.

DECISION

The appeal is denied. The Agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 4th day of April, 2007,

in Tallahassee, Florida.

Linda Garton

Linda Garton
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

APPEAL NO. 07N-00027

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened on March 14, 2007 at 11:55 a.m. at the nursing facility. The petitioner was not present but was duly represented by her granddaughter, . assisted by her nephew, . The respondent was represented by , administrator, with testimony available from ., business office manager.

ISSUE

At issue was whether or not notice of intent to discharge was correct based upon nonpayment following reasonable and appropriate notice to pay. The facility has the burden of proof.

FINDINGS OF FACT

The petitioner has been institutionalized due to health problems since the end of October 2006, following knee surgery. For a time, cost of skilled nursing care was covered by Medicare, but custodial care has been in place since December 21, 2006.

The petitioner is not legally incompetent but has received assistance in the Medicaid application process by various family members, some in Florida, and some in the Northeast. The facility staff became aware of the possibility that three recent Medicaid applications had been denied. The granddaughter had not received notice of the last, and most recent potential denial. Without an official copy of the alleged denial, no finding of fact is made as to Medicaid denial status. However, it can be found that there is no confirmation of Medicaid approval status.

Acting on a presumption that the petitioner's income from either Supplemental Security Income or Social Security was only $550 per month (based upon the granddaughter's assertion of such on a Medicaid application form) and believing that Medicaid authorization would occur, nursing facility billing statements were issued for a patient liability amount of approximately $550 per month, shown in Respondent's Exhibit 2. As of February 1, 2007 the billing statements (issued to a relative in New Jersey) showed amount due of $3050.

Based upon a determination of payment nonreceipt, following what facility staff believed was reasonable and appropriate notice to pay, facility staff issued Nursing Home Transfer and Discharge Notice on February 1, 2007, Respondent's Exhibit 1. A hearing was requested timely, as shown in Petitioner's Exhibit 1. Additionally, upon receipt of the hearing request, the undersigned had directed a survey be conducted by the Agency for Health Care Administration (AHCA) and facility staff believed such had occurred, without a citation of deficiency. However, as of date of hearing, survey results were not available for admission into evidence and no finding is permitted as to AHCA survey results. In any case, an AHCA survey could have relevance to the

administrative hearing process, but AHCA conclusions are not controlling to the fair hearing process. Thus, if AHCA survey results are received by the undersigned after the hearing, such will not be used for any type of evidentiary purpose.

After issuance of the discharge notice, some payments were subsequently received by the facility, and on March 1, 2007, the amount set forth as owed was $1658.25. Then $1200 was paid in March before date of hearing. The amount paid continued to leave a remainder due of at least $458. Additionally, the facility discovered that the petitioner may have more income than initially determined. There is a small pension that had not been known and the federal income benefit actually may be more than $550 per month. Consequently, as of date of hearing, business office staff continued to assert that insufficient payment had occurred and intent to discharge remained.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Additionally relevant is § 483.12 informing as follows:

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
>
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
>
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...

> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. ...
>
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;
> ...
> (7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Findings of fact show the facility has made repeated efforts at achieving payment, and repeatedly sent billing statements. Significant payments were received and that is noteworthy. However, evidence has firmly established that insufficient payment has occurred and the payments made did not fully resolve the problem. Additionally, facility staff opines that Medicaid authorization may not occur and that payment problems may worsen. They do not wish to maintain the petitioner in the facility in that circumstance.

Difficulties in communications, inaccurate knowledge of income amounts, locations of family members and difficulty in physically achieving payment do not

provide remediation of the problem at hand. Sufficient payment simply has not occurred. Payment for a stay at a nursing facility is required. It is concluded that reasonable and appropriate notice to pay did occur and there has been insufficient payment made for services rendered. Discharge to another location has been justified so long as it is a safe location and following proper planning along with orientation.

DECISION

The appeal is denied. Intent to discharge is upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 22nd day of March, 2007, in Tallahassee, Florida.

J W Alper
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To

Respondent
Administration

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07N-00035

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 13, 2007, at 1:20 p.m., at , in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by her daughter, . Present as witnesses for the petitioner were the petitioner's on-in-law, , and the ombudsman, . The respondent was represented by , risk manager. Witnesses for the respondent were l , administrator, and social services director.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge from the notice of February 8, 2007 is in accordance with the requirements of the Code of Federal Regulations at 42 C.F.R. § 483.12:

> (a)(2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

FINDINGS OF FACT

The petitioner entered the facility from the hospital. At the time of admission to the facility, the petitioner was not eating, had a nasal-gastro tube and could not walk. While at the facility, the petitioner's physical and mental health greatly improved. The petitioner is now ambulatory and high functioning.

On February 1, 2007, the petitioner was found wandering in the six lane road in front of the facility. When asked why she had attempted to go across the street, she replied that she wanted some potato chips. The facility procedures require the petitioner to sign out and advise staff if she wishes to leave the tactility. The rationale for this policy is for the safety of the petitioner and liability concerns of the respondent. If petitioner signs out and wishes to leave but is unaccompanied, the petitioner is to be accompanied by a staff member for her safety. The petitioner did not follow these procedures nor was she accompanied by a staff member.

In response to the elopement, on February 2, 2007, the petitioner was placed on the second floor as a deterrent. The second floor area is semi-secure

requiring a code pad entry. Egress from the area is accomplished by hold the door lever for 20 second. The facility considers a secure area to be an area in which a resident cannot egress on their own. Therefore, the facility does not consider the area the petitioner is in to be a secure area.

On February 4, 2007, the petitioner left the second floor by the rear stairway to the back of the facility at 10:30 p.m. The petitioner was able to hold the lever the 20 second and egress from the second floor. The rear door has no reentry. The petitioner went to another facility down the street. This route presented a safety issue with the busy six lane road and late at night. Based on the description given by the facility and the petitioner's ability to egress from the second floor area, the hearing officer finds that the facility is not a secured facility.

On February 5, 2007, the petitioner's treating physician, [redacted] M.D., ordered one-to-one observation and a wanderguard placement for the petitioner. The wanderguard is an electronic device placed on the resident or their wheelchair that causes an alarm to go off, if the resident attempts to leave the building. As a result of the petitioner's elopement and the concern for the petitioner's safety, the petitioner was placed in a one-on-one situation where a staff member is with the petitioner at all times.

On February 8, 2007, Dr. [redacted] signed an order for petitioner to be discharged to a facility with a secure unit. The facility sent the petitioner and her representative a Nursing Home Transfer and Discharge Notice.

On February 13, 2007, Dr. [redacted] and a psychiatrist evaluated the petitioner cognitive ability, such as the understanding of her actions and safety risks and the ability to be responsible to sign herself out of the facility. Both doctors signed that the petitioner was not cognitive, had poor judgment and impulse issues.

The risk manager and the administrator opined that the facility cannot meet the petitioner's safety needs. The second floor area is only a semi-secure area, is only a deterrent and is not fully secure as other facilities. There was no alarm on the front door or key pad entry on the second floor until after the petitioner eloped twice. The petitioner is currently on a one-to-one staffing; however, the facility cannot continue to provide the petitioner with one-to-one staffing.

The daughter and the son-in-law opined that the facility is no different than any other facility with a key pad entry and an alarm and are concerned for the psychological impact of a move by the petitioner to a new facility. The daughter agrees that the petitioner cannot remember something from one day to the next and does not know what she wants. The petitioner did wander when she was at the daughter's home; however, it was on a golf course.

CONCLUSIONS OF LAW

Federal Regulation limits the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case the petitioner was sent notice indicating that she would be discharged from the facility in accordance with Code of Federal Regulations at 42 C.F.R. § 483.12:

(a)(2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

The facility documented incidents by the petitioner that led to the facility issuing a notice for discharge. The documentation included two elopements from the facility. The petitioner was diagnosed as not cognitive, has poor judgment and impulse issues. There is no evidence by statement of the treating physician that the move would be detrimental to the petitioner's health. No evidence was brought forth that contradicted the fact that a physician indicated placement at a secure facility. No evidence was brought forth that contradicted the fact that a physician signed the discharge notice. This indicates that a physician concurred with the discharge. The administrator and the director of nursing opined that Carrington is not a secure facility and as such the facility cannot meet the petitioner's safety needs. Therefore, the hearing officer concludes that the discharge is consistent with the recommendation of Dr. and the transfer or discharge is necessary for the resident's welfare.

DECISION

This appeal is denied as the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file

one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 3rd day of April, 2007,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

APPEAL NO. 07N-00034

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 4:20 p.m. April 18, 2007 in the Manor on the Green. The petitioner represented himself with assistance from his son, , MD. Also present with the petitioner was of the Long Term Care Ombudsman Office. The respondent was represented by social service director, with testimony available from , business office manager; RN, assistant director of nursing; , occupational therapy assistant; and , physical therapist.

ISSUE

At issue was whether or not notice of intent to discharge was correct based upon nonpayment following reasonable and appropriate notice to pay. The facility would have the burden of proof.

FINDINGS OF FACT

1. The petitioner has been institutionalized due to significant health problems since October 2006. Both occupational and physical therapies have occurred.

2. Admission of the petitioner to the facility initially occurred under Medicare coverage. A period of insurance coverage (under New Jersey Blue Cross/Blue Shield) also occurred through January 24, 2007 with therapy in place.

3. As of January 31, 2007, for services rendered and for which no insurance payments had occurred, the remaining nursing facility "balance" owed was $980, set forth in Respondent's Exhibit 2, page 1. The amount owed for the period of February 1 through February 28, 2007 was also set forth on that bill as $3920 (page 1 of Respondent's Exhibit 2). The total "amount now due" was shown as $4900 on the bill issued January 25, 2007.

4. Based upon facility staff's determination of payment nonreceipt following what facility staff believed was reasonable and appropriate notice to pay, staff issued Nursing Home Transfer and Discharge Notice on February 5, 2007, Respondent's Exhibit 1. A hearing was requested timely, as shown in Petitioner's Exhibit 1.

5. Upon receipt of the hearing request, the Agency for Health Care Administration (AHCA) was directed to conduct a noncontrolling survey. The survey was completed and regulatory noncompliance was not found (Hearing Officer Exhibit 1, as shared with the parties).

6. On February 27, 2007, the business office manager issued further correspondence (page 2 of Respondent's Exhibit 2) informing that "we have billed your

insurance as a ***courtesy*** (emphasis included), and this balance is still your responsibility." Page 3 showed "amount now due" as $13697.23."

7. While the petitioner has been pursuing his own insurance carrier for coverage, no nursing home payment plan was in place or underway, since issuance of the January 25, 2007 bill.

8. The petitioner anticipated that his insurance coverage might be approved with an appeal made through Blue Cross, due to continuing need for therapy with his unstable hip. He has been contacting doctors.

9. As of the date of the hearing, insurance coverage had not been authorized nor had payments been made to the facility for care received since the January 25, 2007 billing statement. While recognizing efforts of the petitioner to pursue insurance coverage, the facility did not wish to rescind the discharge intent set forth on notice.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Additionally relevant is § 483.12 informing as follows:

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
>
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
>
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...

> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. ...
>
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;
> ...

Findings of fact show the facility has made repeated efforts at achieving payment, and repeatedly sent billing statements. Some payments were received in past months and some insurance coverage paid for care and those are noteworthy factors. However, evidence has firmly established that insufficient payment has occurred and past payments made did not achieve resolution of the problem. Facility staff does not wish to facilitate continuation of care under current financial circumstances.

Difficulties in communications with doctors, difficulties in achieving insurance coverage, anticipation of insurance coverage approval, as well as obstacles encountered by the petitioner do not provide remedy for the problem at hand. Sufficient payment simply has not occurred. Adequate payment for continuing stay at a nursing

facility is required. It is concluded that reasonable and appropriate notice to pay did occur and there has been insufficient payment made for services rendered. Discharge to another location has been justified.

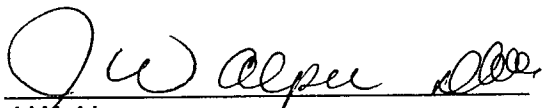
DECISION

The appeal is denied. Intent to discharge is upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 30th day of April, 2007, in Tallahassee, Florida.



J W Alper
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07N-00042

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 12, 2007, at 10:00 a.m., in Bonifay, Florida. The petitioner was not present but was represented by his sister, . Testifying on behalf of the petitioner was his brother in law, and Ombudsman program. The nursing facility was represented by , facility risk manager, MDS coordinator, I , previously known as . Testifying on behalf of the nursing facility was , RN, unit manager; , director of nursing; , social services director and , administrator.

ISSUE

At issue is the February 20, 2007 discharge of the petitioner from the nursing facility.

FINDINGS OF FACT

Prior to the action under appeal, the petitioner, age 49, was admitted to the nursing facility under Medicare. His initial admission was June 15, 2006 and he was discharged to the hospital on July 2, 2006. The petitioner was readmitted to the facility on July 12, 2006 until his discharge on February 20, 2007. The petitioner is mentally retarded and was admitted with a diagnosis of right inguinal hernia repair, pituitary mass, visual loss, hyperlipidemia, edema and hypothyroidism. His sister is his health care proxy and payee of his income. The petitioner has not been determined incompetent and there is no legal guardian.

The respondent presented copies of progress notes describing incidents that occurred between the petitioner and his sister on October 10, 2006, October 31, 2006 and February 2, 2007 that led the facility to institute supervised visitations beginning November 1, 2006. The supervised visitations were initiated by the nursing facility in order to ensure the petitioner's safety while under its care. In addition, the respondent reported allegations of mental and physical abuse to Adult Protective Services via the abuse hotline on at least two occasions on October 31, 2006 and February 2, 2007.

It was after the February 2, 2007 incident that the petitioner began indicating his desire to leave the nursing home. The nursing home made several attempts between

February 2, 2007 and February 20, 2007 to locate another facility which would be closer to the petitioner's oncologist where he could receive radiation therapy. The respondent contacted several nursing facilities; among them were

Home. The respondent was unsuccessful in finding an alternate placement for the petitioner.

On February 20, 2007, the petitioner returned to the nursing facility after a medical leave of absence. The petitioner's representative advised the staff that she wanted the supervised visitations to be stopped. The respondent refused to lift the supervised restriction on visitation. As a result, the petitioner and his family indicated that the petitioner wanted to be discharged and the nursing facility physician was contacted to provide the post discharge plan of care. The facility testified that it did not initiate the discharge but that the petitioner requested to be discharged home with his sister and as a result, a discharge/transfer notice was not completed.

The petitioner's sister does not agree that she requested the petitioner be discharged. She believes that she was forced to take him from the facility and signed the post discharge plan of care against her will. The petitioner signed the post discharge plan of care because the nursing home would not release the petitioner's medication.

At the hearing, the Long Term Care Ombudsman representative indicated that an investigation into the allegation of improper discharge had been conducted. It was determined that the facility was not at fault as there was no discharge notice. The petitioner has not been adjudicated and has no legal guardian. Therefore, the petitioner may choose to leave the facility. In addition, the petitioner was not present to represent himself and was unavailable to indicate his desire during the hearing.

Petitioner's Exhibit 1 is the confidential Investigative Decision Summary Narrative from the Department of Children and Families. This report indicates contact with both the petitioner and his sister. The report indicates the petitioner defended his sister and chose to leave the facility and live with her. This report indicates that placement outside of the home is required and that supportive services are in place to assist with finding placement.

The petitioner's representative indicated that the petitioner would not want to return to the nursing facility unless it was under duress. He would be willing to return to the facility so that he could receive medical care only until he was able to find other suitable placement.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by federal regulations appearing in 42 C.F.R. §431.200. Additionally, federal regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearing, states in part:

> (10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.
>
> (17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and **not by the resident or by the resident's physical or legal guardian or representative**.

In this case, the nursing facility did not issue a notice of transfer/discharge as the discharge was not initiated by the facility.

The petitioner's representative argues that she did not voluntarily discharge her brother from the facility. She further argues that she signed the Post-Discharge Plan of Care "against her will" only so that the nursing home would release his medication when he left the facility. Evidence in the record supports that the petitioner chose to leave the facility and live with his sister. In the absence of any evidence to the contrary, the undersigned authority rejects the petitioner's representative's argument that the discharge was initiated by the nursing home.

According to the above authorities, the provisions of the above cited discharge and transfer statute giving hearing rights, applies only to transfers or discharges that are initiated by the nursing home facility, and not by the resident or by the resident's physical or legal guardian or representative. Therefore, the hearing officer concludes

that because the discharge was voluntary, there are no hearing rights and there is no appealable issue. Therefore, this appeal is hereby dismissed.

DECISION

The appeal is dismissed.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 25th day of April, 2007,

in Tallahassee, Florida.

Linda Garton

Linda Garton
Hearing Officer
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Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07N-00013

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 21, 2007, at 3:50 p.m., at in Stuart, Florida. The petitioner and her husband were present. , the petitioner's son, represented her. , business officer manager, , represented the respondent. The nursing home administrator gave written permission to represent the facility in her absence. , social services director, was present as a witness for the respondent.

ISSUE

The respondent has the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of January 5, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

FINDINGS OF FACT

The petitioner has incurred expenses at , for her residence in the facility. She owes the facility $1517.36 (Respondent's Exhibit 6). The balance owed is for a partial room differential for January 2006, and patient responsibility for February and March 2006. She remains a resident there pending the outcome of this appeal. An Order to Stay Discharge was filed on February 23, 2007 as the petitioner had filed an appeal on this matter in a timely manner.

Prior to January 2006, the petitioner was in a private room at and had a zero patient responsibility. The Department of Children and Families had erroneously budgeted income when determining eligibility for Medicaid coverage for her. Her son received a Notice of Case Action from the Department of Children and Families dated February 20, 2006, informing him that his mother's patient responsibility at the nursing facility was going to be $743.68 effective February 1, 2006 (Petitioner's Composite Exhibit 1). She was moved from her private room to another room but incurred some expenses before the move.

In an attempt to collect the balance owed, the facility sent the petitioner's son a letter and enclosure by regular mail on April 20, 2006 informing him that there was an

outstanding balance on his mother's account of $1797.36. A Promissory Note requesting monthly payments of $250 was the enclosure. The facility expected the first $250 payment on May 10, 2006, along with the regular monthly payment of $743.68 (Respondent's Exhibit 2). On June 20, 2006, another letter was sent to by regular mail informing him that the account had an outstanding balance of $1517.36. The letter stated it was for the "months of April, March, and part of February". A Promissory Note requesting payments of $250 was enclosed with the first payment due on June 20, 2006 (Respondent's Exhibit 3).

On December 26, 2006, a final letter was sent to certified mail informing him if payment was not received by January 5, 2007, the facility would start discharge proceedings (Respondent's Exhibit 4). On January 5, 2007, a Nursing Home Transfer and Discharge Notice was issued to the petitioner notifying her that she was going to be discharged on February 5, 2007, to her husband at their residence (Petitioner's Exhibit 2).

agrees that the money is owed to the facility. He does not recall any telephone conversations with the facility concerning the matter. His wife signed for the certified mail, but he does not recall receiving the June 20 letter with the Promissory Note. His father is on a fixed income now that there is a patient responsibility, he has been paying some of his bills for him. He does not have the means to pay $250 per month for the $1517.36 balance at the facility, but believes he could pay $25 per month towards the balance.

The above described discharge notice shows that the petitioner is to be discharged to her husband. The respondent and the petitioner agree

that the petitioner requires skilled nursing care. Despite issuance of the notice of intent to discharge to the petitioner's home, the facility does not intend to discharge the petitioner to an unsafe location and discharge would only occur with planning and orientation as required by regulation. The facility explains that 14 nursing facilities have been contacted throughout Florida while seeking placement for the petitioner in discharge planning. One facility in West Palm Beach has an available bed. The petitioner's family has visited area nursing facilities and has placed her on a waiting list for an available bed.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal regulations appearing at 42 C. F. R. §431.200 and Florida Statute 400.0255.

Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates that petitioner is to be discharged from the respondent's facility based on non-payment. Federal Regulations do permit a discharge for this reason as set forth at 42 C. F. R. §483.12 and states:

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
>
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
>
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...

> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. ...
>
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;
> ...
> (7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The Findings of Fact show the facility has made numerous attempts by mail to collect payment. No conversations occurred between the petitioner's son and the facility concerning the Promissory Notes that were sent with the letters requesting payment. Evidence has established that insufficient payment has occurred.

Reasonable and appropriate notice to pay did occur and there has been insufficient payment made for services rendered. Discharge to another location is justified so long as it is a safe location and following proper planning along with orientation.

DECISION

The appeal is denied. The action to discharge the petitioner from the facility for nonpayment is upheld. The nursing facility may transfer the petitioner after finding an alternate location that is safe and appropriate.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 9th day of April, 2007,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
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Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07N-00022

PETITIONER

Vs.

NHA CARY LAKE

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 8:55 a.m. on April 6, 2007 at the . The petitioner represented herself and the respondent was represented by administrator. Also present were the business office manager, , and social service director, .

ISSUE

At issue was whether or not discharge to "SNF to be determined" was correct due to nonpayment of a bill following reasonable and appropriate notice to pay. Burden of proof was upon the respondent with an evidentiary standard of clear and convincing.

FINDINGS OF FACT

On January 19, 2007, notice was issued to the petitioner that discharge was intended as follows: to "SNF to be determined" due to "bill for services at this facility

has not been paid after reasonable and appropriate notice to pay" (Respondent's Exhibit 1). The petitioner requested a hearing (Petitioner's Exhibit 1).

When the Office of Appeal Hearings received the hearing request, the office directed a survey to be conducted by the Agency for Health Care Administration. This occurred on February 14, 2007 as shown in the survey (Hearing Officer Exhibit 1). The following deficiency was noted by AHCA: "A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer...this REQUIREMENT is not met...name and an address indicating a location was not included in this form."

As of date of hearing, the facility had completed a corrective action plan (Respondent's Exhibit 2). However, the notice issued by the facility on January 19, 2007 had not been rehabilitated, revised or reissued in any way with regard to the petitioner's situation. The facility staff had not identified another SNF for discharge of the petitioner.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Additionally relevant is § 483.12 informing as follows:

Admission, transfer and discharge rights.

(a) Transfer and discharge--

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. ...

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
...
(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
(iii) The location to which the resident is transferred or discharged; (emphasis added)
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
...
(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Facts show no meaningful location for discharge has been identified on the notice issued January 19, 2007 and no location for discharge had been identified as of date of hearing. The problem as to discharge location had not been remedied as of convening of hearing. Therefore, the notice cannot be considered adequate and the discharge action cannot be considered as justified. Requirement to show a location on the discharge notice may not be waived.

Discharge location is not an optional item under regulation and the AHCA noted this defect in the survey AHCA conducted. Location of intent to discharge is a critical component of the discharge process and "SNF to be determined" cannot be concluded by the hearing officer to be a meaningful declaration of location.

DECISION

The appeal is granted and the discharge action is not upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 11th day of April, 2007, in Tallahassee, Florida.

J W Alper
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07N-00028

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 15, 2007, at 9:02 a.m., at , in North Miami, Florida. The petitioner was not present, but was represented at the hearing by her sister, The respondent was represented at the hearing by administrator, Also present on behalf of the facility were business office manager and , director of social services. Present as an observer was .

ISSUE

The respondent notified the petitioner that she was to be discharged for the following reasons: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay..." The respondent will have the burden of proof to establish

by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. § 400.0255.

FINDINGS OF FACT

The facility notified the petitioner on or about January 31, 2007 that she was to be discharged by March 1, 2007. The discharge location that was given was: "[." This is the petitioner's sister's home. Currently the petitioner resides at '

The petitioner received an outstanding bill from the facility based on her failure to pay for her stay at the facility. Respondent Exhibit 1 indicates that as of December 31, 2006, the petitioner's outstanding nursing home bill was $1,922.45. As of February 14, 2007, the petitioner's outstanding nursing home bill was $2,330.70, Respondent Exhibit 1. Respondent Exhibit 1 also contains copies of nursing home bills for the petitioner. The bills are dated in late October 2006; in late November 2006 and on or about December 23, 2006. The respondent; however, indicated that the respondent did not provide an actual bill to the petitioner's representative until late January 2007. As of the date of this hearing; the overdue bill for the petitioner's stay at the facility has not been paid to the facility.

The petitioner was approved for ICP and Medicaid benefits by the Department of Children and Families on January 18, 2007. The respondent indicated that the petitioner's unpaid bill represents the petitioner's patient responsibility amount as assigned by the Department of Children and Families to the petitioner, Respondent Exhibit 1.

CONCLUSIONS OF LAW

The Code of Federal Regulations at 42 C.F.R. § 483.12(a)(2) sets forth reasons for which a resident may be discharged, and states in part:

> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;...
>
> This regulation continues and states in part:
>
> (4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following:...(iii) The location to which the resident is transferred or discharged...

As shown in the Findings of Fact, the facility notified the petitioner on or about January 31, 2007 that she was to be discharged by March 1, 2007 to: "I Currently the petitioner resides at The discharge reason is: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay...". The respondent; however, did not provide a bill; due or overdue to the petitioner or her representative until the approximate time the notice of discharge was provided to the petitioner.

The petitioner's representative argued that the discharge location provided is not a medically appropriate location for discharge. She argued that she was not aware of any of the charges from the facility for the petitioner's stay at the facility. She argued that she did not receive any bill from the facility for the petitioner.

The respondent argued that the petitioner's representative had previously been made aware of "charges" the petitioner was to receive for her stay at the facility. The

respondent also indicated that the facility is willing to work things out with the petitioner, if the bill can be paid at the facility.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to discharge the petitioner is not appropriate as the respondent did not allow the petitioner; reasonable and appropriate notice to pay the bill at the facility. The facility has not met its burden of proof and is not in compliance with the appropriate federal regulation noted above for the discharge of January 31, 2007; for March 1, 2007 to be appropriate.

DECISION

This appeal is granted and the facility's action is not upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 9th day of April, 2007,

in Tallahassee, Florida.

Robert Akel

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